

Collaborative Name:

Building Healthier Places Through Neighborhood Transformation (BHPTNT)

Name of Lead Entity:

Region 1 Planning Council

All Collaboration Members:

Region 1 Planning Council

Swedish American, a Division of UW Health

Mile Square

Rockford Regional Health Council

Rockford Housing Development Corporation

Proposed Coverage Area:

Winnebago County

Area of Focus:

Improving the Social Determinants of Health in the disinvested neighborhoods of Winnebago County to improve health outcomes of racial and ethnic groups disproportionately affected by poor Social Determinants of Health with the overall goal of improving health outcomes and reducing cost and strain on medical and healthcare-related systems and facilities for the region.

Total Budget Requested:

\$29,645,249 Total project budget.

\$11,880,000 Matched from other sources.

\$17,765,249 Requested

BHPTNT Outline

1. Participating Entities

a. Contact Information for Collaborating Entities

We believe that to truly transform health, patients' physical health, behavioral health and social needs must be addressed in a coordinated way within their community. Given this, we are looking for collaborations that represent a broad and meaningful spectrum of the healthcare, behavioral health and social determinants of health delivery system at the community-level

Note: HFS is seeking to know in which MCO networks each hospital in your collaborative participates.

i. What is the name of the lead entity of your collaborative?

Region 1 Planning Council

ii. Please provide primary contact information, secondary contact information, and the Tax ID # of each entity in your collaborative. Please list the lead entity in the top row.

iii. Please upload the most recent IRS Form 990 (including Schedule H, if applicable) for all participants in the collaboration. (Note: These 990s will all have to be compiled into a single PDF file.)

b. Please list the names of the entities in your collaborative that are either certified by the Illinois Business Enterprise Program (BEP) or not-for-profit entities that are majorly controlled and managed by minorities.

Rockford Regional Health Council

c. Please list the Medicaid-eligible billers (firms that can bill Medicaid for services) in your collaborative, and the Medicaid ID for each.

d. Any other supporting documents?

2. Project Description

a. Brief Project Description

- i. **Provide an official name for your collaboration. NOTE: Please ensure that this name matches the name given in the "Application Name" field in the Project Information form at the beginning of the application.**

Building Healthy Places Through Neighborhood Transformation
BHPTNT

- ii. **Provide a one to two sentence summary of your collaboration's overall goals.**

We will increase healthcare access for residents living in disinvested neighborhoods in the Rockford area through mobile health solutions while also improving the conditions in these neighborhoods through housing and food systems development.

- iii. **Provide a narrative description of your overall project, explaining what makes it transformational.**

Specify your service area, identify the healthcare challenges it faces, and articulate your goals in addressing these challenges; explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe for the project.

Describe any capital improvements, new interventions, delivery redesign, etc. Your narrative should explain the need for each significant item in your budget, clarifying how each connects to the overall goals and operations of the collaboration.

Region 1 Planning Council (RPC) will gather, process, and present data on the communities being served and Winnebago County at large to inform the collaborative's response and efforts. This data can also be used to inform other healthcare and public health bodies in the region.

The data will be presented as a publicly visible data dashboard website which will have descriptions and data visualizations tracking progress of various measures of healthcare outcomes, healthcare statistics, and measurements of various social determinants of health.

The data dashboard will use de-identified data from our collaborative partners and potentially from other healthcare and public health bodies in the region. This data will be combined with publicly available regional data on health and the social determinants of health.

The dashboard will be updated at regular intervals to be decided by the collaborative partners and Region 1 Planning Council after the collaborative's efforts begin. How frequently the collaborative partners will be able to provide adequately de-identified data will not be known until they start serving the community and how regularly they will update their strategies and operations may be subject to change. The number of clients served and how well the data can be deidentified determines this frequency. A general rule is to have more than 10 individuals in a given category before publishing any information on it to avoid identification. For the best and most adaptable program the intervals of data processing and use will be decided as the project gets off the ground and into the real world.

The data dashboard will also be used as guidance for determining where mobile health solutions are most needed to increase health care access. The collaborative's two healthcare partners will work together to provide a mobile health unit that includes nursing and access to behavioral health and primary care through a mobile device. This program is an expansion of a Mobile Integrated Health partnership between Swedish American and the Rockford Fire Department, which has reduced emergency room visits by focusing on follow-up visits with super-utilizers. This new unit will build on this partnership with the City of Rockford, further expanding to include a managed care provider, Molina Health, who will provide the van for this unit. The City of Rockford will expand its scope to include facilitating connections to supportive services and poverty mitigation resources. This unit will be available for direct neighborhood outreach as well as targeted community events, to increase both direct access to health care and also community education and awareness about physical and mental health.

The Building Healthy Places through Neighborhood Transformation Program will address food insecurity and physical and mental preventative health behaviors in part through the Nourished Neighborhoods Program. The Nourished Neighborhoods Program will support local communities and build more resilient food systems to address lack of access to

affordable, fresh, and local foods throughout Winnebago County. This program will focus on supporting local food production through urban agriculture to grow food directly in impacted neighborhoods, while also providing job-readiness opportunities for youth and adults. Secondly, the Nourished Neighborhoods Program will address food distribution and systems change through education and outreach. Lastly, the Nourished Neighborhoods Program will promote the use of green space to benefit mental and physical health.

Region 1 Planning Council (RPC) will lead the planning, convening, and facilitating efforts of the Nourished Neighborhoods Program. The first task of the program will be the creation of the Nourished Neighborhoods Coalition. The Nourished Neighborhoods Coalition (NNC) will consist of community, government, and other relevant stakeholders who will meet to help create a framework for approaching the Nourished Neighborhoods Program. Next, RPC will create and facilitate a notice of funding opportunities (NOFO) for a local community organization(s) to implement the outlined program activities in their respective neighborhoods. The NNC will be involved with the NOFO process and will serve on the selection committee. In addition, RPC will work with the Rockford Housing Development Corporation (RHDC) to coordinate with a local community organization to operate their urban farm and educational programming. The Nourished Neighborhoods Program will also work with the Northern Illinois Land Bank, housed at RPC, to analyze and determine whether vacant lots in the project area can be used for this program.

The process for developing and publishing a Notice of Funding Opportunity (NOFO) will consist of inter-agency collaboration to create a comprehensive document. This document will contain several components, including a scope of work, task breakdown, vendor qualifications, pricing proposal, and a notice of funding opportunity form. This form provides preference to minority organizations in the most vulnerable communities, including Business Enterprises for Minorities, Women, and Persons with Disabilities. This criteria selection will help to identify the target populations that require and would benefit the most from healthcare and food assistance. The Nourished Neighborhoods Coalition will provide direction in the creation of the NOFO as well.

RPC will subsequently post answers to these questions, and once the NOFO is published online, prospective vendors will be able to submit questions on it for proposals for approximately one additional week. The process of reviewing submissions, determining a preferred vendor, and

undergoing negotiations will follow for approximately one month. Once this round is completed and a selection of the preferred response has been made between RPC and the preferred vendor, additional negotiation can occur for another two weeks if necessary. Finally, the notice of award is published to all and work can begin to implement the scope of work outlined in the NOFO.

NOFO/Local Community Organizations Tasks & Responsibilities:

- Build and operate RHDC urban farm and educational activities.
- Build and operate other urban farms and greenhouses using land bank vacant lots or other priority areas identified by R1.
- Build and operate demonstration/pilot sites for projects like food forests, rooftop gardens, or vertical farming.
- Incorporate workforce development or job readiness programs into all projects, addressing the most vulnerable populations.
- Incorporate a CSA or boxed food delivery program into all project activities.
- Incorporate healthy food outreach and education into all urban farming project activities.
- Work with local farmers markets and co-ops to bring locations to targeted communities.
- Coordinate with RPC's strategic planning initiatives as it relates to supporting local food systems and addressing social determinants of health.

Rockford Housing Development Corporation will add to these efforts by using a Social Determinants of Health framework for housing development. Housing development efforts will take two tracts: 1. A large, mixed-use housing development with thirty-eight low-income apartment units and first-floor commercial space targeted for nonprofits who serve residents of the neighborhood. This development will be adjacent to a local FQHC that provides primary care and behavioral health, both integrated with urgent care. Beginning in Year 2 of the proposed project, they will also partner with Habitat Humanity to build new houses in disinvested neighborhoods on vacant land to improve home values and increase access to housing in these neighborhoods. Habitat will use its proven model for the five neighborhood homes it will build annually.

The largest expenses will be the construction of mixed-use residential buildings, construction of homes by Habitat for Humanity along with the

construction of a playground/outdoor park. RHDC will cultivate and negotiate construction agreements, beyond Habitat for Humanity with minority-led nonprofits and/or nonprofits that serve to benefit minority populations by employing an equity lens on the construction process so that jobs and the ultimate homeownership programs maximize benefit for minority populations. In addition to new home infill construction, Habitat for Humanity runs a critical home repair program to ensure existing homeowners can maintain their homes and preserve their value – with benefit for both the homeowner and the neighborhood. The budget includes varying values by year to accommodate the launch and scale of this essential work to create critical mass and complete blocks of stabilized properties. The 5-year project will renovate at least 38 homes. The budget includes an annual request (years 2-5) to subsidize 3 (of the 5) homes for Habitat and an escalating value (see budget) to fund additional infill housing on the South Avon sites and other nearby lots, currently owned by the land bank, to build a critical mass of high quality and energy efficient homes within walking distance to Crusader Community Health Clinic. Affordable and safe housing is critical infrastructure both for individual households and for communities at large. Decent housing is the keystone that allows other areas of life to align and fall into place. By building new homes, rehabilitating existing homes, and assisting with critical repairs and aging in place projects for existing low-to-moderate income homeowners, we can ensure Rockford households and Rockford neighborhoods achieve this critical keystone for strength, stability, and independence.

Community input on core parts and priorities of the collaborative's efforts will partially take the form of community surveys. Surveys have notoriously low response rates so we want to ensure a wide enough net to reach as many people in as many different ways as possible. This needs to be a community-focused project.

- b. [Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)**

3. Governance Structure

Note on the significance of governance structure:

We recommend you consult the [HFS Guide to Collaborations](#) for your reference as you develop your governance structure.

The governance section should reflect serious thought regarding the execution, management, accountability, and interreliance of the participating members of your collaboration. It should be clear how the structure and governance will

bind the various participating organizations into an interrelated enterprise to accomplish the scope of work and the promised outcomes of the proposal. A well-developed governance process is the engine that will drive the effective

implementation of the project. Absent quality governance, great ideas and good intentions often fall short or fail altogether

a. Structure and Processes

- i. Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated and priorities set?**

There will be a working group for each of our collaborative's partners. This working group are the ones tasked with accomplishing that partner's goals for the BHPTNT collaborative. There will also be a working group composed of individuals of the disinvested, Black, and Hispanic communities with lived experience. This working group will be known as the "Real People Working Group". The partners for the BHPTNT Collaborative are Swedish American, Mile Square, the Rockford Housing Development Corporation (RHDC), Region 1 Planning Council (RPC), and the Rockford Regional Health Council (RRHC).

Each of these working groups will elect one of their own to sit on a group known as the Core Team. This Core Team will help each partner coordinate activities and serve as a forum for each group to share information. Though each working group and collaborative partner will have decision making power over its own activities, the Core Team will set priorities and formulate policies for the collaborative as a whole.

The convener of the Core Team will be a full time employee of Region 1 Planning Council. This employee will also be responsible for all coordination and administrative work for the Core Team.

The Core Team will communicate and coordinate with the large healthcare network and community through the Rockford Regional Health Council (RHHC). The Core Team is independent of the Rockford Regional Health Council. Many of the proposed collaborative's partners are also represented on the Rockford Regional Health Council. The relationship between the Core Team and the RRHC purely of communication and coordination.

Swedish American will act as the fiscal agent for the collaborative and delegate some financial powers as needed to Region 1 Planning Council (RPC). RPC will act as a financial intermediary. All funds will be dispersed at the discretion of RPC on the advice of the Core Team and/or the appointed representative of the Real People Working Group.

In order to ensure that members of the community and target populations facing healthcare disparities are meaningfully represented, the collaborative will ensure participants are compensated for their time at meetings via vouchers. Each participant will be paid a stipend of \$20 per hour including reimbursements for travel costs. . Many of those this collaborative intends to serve may not be able to participate meaningfully or fully if they cannot be compensated for their time.

b. Accountability

- i. How will collaborating entities be made accountable for achieving desired outcomes? How will the collaboration be made accountable for acting prudently, ethically, legally, and with extensive participation from each participating entity? What methods will be used to enforce policy and procedure adherence?**

At each convening of the Core Team, a representative from each working group and collaborative partner will present their current progress as well as what they aim to accomplish by the next meeting. The Core Team will then set priorities for the collaborative partners and ensure that all members are acting in accordance with their promises. If needed, the Core Team will have the authority to advise RPC to not administer funds to a participating entity if they do not adhere to the collaborative's policies and procedures or timeline.

Data on the collaborative's efforts will be submitted to RPC and processed to create a public-facing data dashboard. The specifics of the data sharing agreements between each partner and Region 1 Planning Council

will be decided later to ensure patient privacy and ethical use of the data. This data dashboard will contain information on the current state of the projects and community or regional level health and social determinants of health statistics. The Core Team and each working group and partner will use this information to inform their current operations.

The working group composed of members of the communities will be served by the proposed project will also have the authority, either as a group or through their appointed representative on the Core Team, to advise RPC to discontinue or withhold funding from any entity or partner that they or their group or community feel is not adequately or ethically working toward the goals of the collaborative.

c. New Legal Entity

- i. Will a new umbrella legal entity be created as a result of your collaboration?**

No

- ii. Please give details on the new entity's Board of Directors, including its racial and ethnic make-up.**

Not relevant

d. Payments and Administration of Funds

Note: It is likely that transformation funds for proposals will come in the form of utilization-based Directed Payments to a healthcare provider(s) or behavioral health provider(s) in the collaboration. These entities will receive a report earmarking these payments as transformation funds. These funds must then be distributed among the collaborating entities.

- i. How will you ensure direct payments to providers within your collaboration are utilized for your proposed program's intended purpose? If the plan is to use a fiscal intermediary, please specify.**

UW Health (aka Swedish American) will serve as fiscal agent for this project, and Region 1 Planning Council (RPC) will act as the collaborative's grant manager and may serve as fiscal intermediary for sub-awards. RPC will hire a full time Grant Manager who will be in charge of coordinating Region 1 Planning Council's efforts with the other collaborative partners,

managing subcontracts and sub-awardees, monitoring and reporting on performance and finance, and managing compliance with the grant. They will also be in charge of convening and managing the Core Team--the collection of representatives from the collaborative's partners and working groups. Additionally, they will be in charge of creating the community input and lived experience working group known as the "Real People" Working Group.

If at any time there is evidence that funds are not being used ethically or in accordance with the collaborative's goals or with the pledged goal of each partner, or for the maximum possible benefit of the racial and ethnic communities facing healthcare disparities which are the focus of this collaborative, RPC will have the authority to discontinue or withhold funding. Additionally, the Core Team can make a recommendation to Region 1 Planning Council to discontinue or withhold funds for the same reasons. Lastly, either the members of the Real People Working Group or their appointed representative on the Core Team can make the recommendation to discontinue or withhold funds for the same reasons.

4. Racial Equity

a. Background on HTC and racial equity:

This form contains a racial equity impact assessment, or REIA. An REIA is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities. (Source: Race Forward - "Racial Equity Impact Assessment")

b. High-Level Narrative

- i. A fundamental focus of healthcare transformation is racial equity. Please provide a high level description of how the design of your proposal incorporates racial equity. (Greater detail will be requested in the questions below.)**

Our proposal seeks to address the disparities that are present in healthcare, housing and accessibility to healthy food options in Black, ethnic, and lower income communities in the region. This will be achieved through the implementation of the Building Healthy Places through Neighborhood Transformation Collaborative.

The neighborhoods the BHPTNT Collaborative will focus on are home to the highest number of Black, Brown, and Hispanic individuals and communities in the region. Services and facilities which we build and improve in these neighborhoods will increase access and improve the environments of Black, Brown, and Hispanic people directly.

Additionally, there will be a working group on the Core Team--the body which prioritizes and coordinates the collaboratives actions--which is made up entirely of people with lived experience or are current residents of the neighborhoods our collaborative intends to serve. This working group will put Black, Brown, and Hispanic individuals facing these challenges on the same footing as the rest of the collaborative's partners and be involved in key planning and priority-setting decisions of the collaborative. Putting the real people we intend to help into the highest level of decision making will have many obvious and less than obvious benefits to ensure racial and ethnic equity are worked toward and maintained.

- ii. **[High Level Narrative - Optional] Please upload any documentation or visuals you wish to submit in support of your response. (Note: if you wish to include multiple files, you must combine them into a single document.)**

c. Racial Equity Impact Assessment Questions

- i. **Which racial/ethnic groups may be most affected by and concerned with the issues related to this proposal?**

Disinvested neighborhoods in Rockford, most of which are on Rockford's west side, have a long history of inequality along racial and ethnic lines compared to the east side. Disinvested neighborhoods are home to the majority of the non-white residents--mainly Black residents--as well as the majority of Black communities. They are also home to the highest amount of housing code violations, fewer education facilities (both public and private), fewer higher education facilities, fewer day care centers, fewer physical healthcare facilities, fewer dental care facilities, fewer mental and

behavioral healthcare facilities (including communities in the south-east which have no real access to any form of healthcare be it physical, mental, primary, emergency, preventative, etc.), fewer people insured, more people reporting “not-good” physical and mental health, fewer options (sometime no options) for healthy or fresh food, lower rates of vehicle ownership, lower rates of reading and math proficiency rates, lower property values per square foot, fewer new construction, older homes, higher numbers of vacant lots, higher number of vacant properties, overall lower quality housing, fewer jobs, and a higher poverty rate.

Reiterating, disinvested neighborhoods are where most Black, Brown, and Hispanic people live in Rockford and where most of the Black, Brown, and Hispanic communities are. Because of the disparities mentioned previously, the focus of this grant will be in those communities, thus affecting mostly Black, Brown, and Hispanic populations.

ii. Have stakeholders from different racial/ethnic groups — especially those most adversely affected or from vulnerable communities — been informed, meaningfully involved and authentically represented in the development of this proposal? Who’s missing and how can they be engaged?

Stakeholders belonging to different racial and ethnic groups have been involved in this proposal in the form of the 2020 Healthy Community Survey that was conducted by RPC, Rockford Regional Health Council, and the Community Health Collaborative. The method of distribution of this survey was conducted in such a way as to voluntarily engage the most vulnerable populations of the community. Physical copies of the survey were distributed in the following manner:

To clients of Crusader Clinic (A health center that offers aid to underserved community members regardless of their ability to pay and a Federally Qualified Health Center)

To visitors of the Northern Illinois Food Bank

To residents of housing units operated by the Rockford Housing Authority, Winnebago County Housing Authority, and Zion Development.

To parents/guardians of students in the Harlem School District and Belvidere District 100.

Surveys were also mailed and emailed to residents, and available online. In addition to English, surveys were also available in Spanish. The results from these surveys provided insight on the issues that racial and ethnic groups are facing in the region and illustrate the needs for these groups. Hispanic/Latino individuals made up less than 5 percent of the survey respondents. Community outreach attempts conducted in the future will make increased efforts to reach out to this group.

Because the input was in the form of a voluntary survey, unavoidably people were missed. Continuing to survey the population through pop-up events, door knocking, or feedback systems at point of care is vital and an entirely feasible method to continue to gather reliable input and engagement from the members of the community, including those who our initial efforts may have missed. There is ample reason to believe many individuals and groups were missed because midway through the Community Health Survey period were forced to move entirely online due to the COVID-19 Pandemic shutdown.

iii. Which racial/ethnic groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequality exists? What evidence is missing or needed?

The most advantaged racial/ethnic group regarding healthcare and food accessibility is white people in the community. White respondents of the 2020 Healthy Community Survey reported having an easier time accessing healthcare than their Black counterparts. When asked about their health, on average, white respondents answered more favorably than Black respondents.

The most disadvantaged racial/ethnic group regarding these issues was Black people. Black members of the community reported having the hardest time understanding medical information when compared to other races and more than half of the Black respondents claimed that they did not trust the information given to them by their medical provider. Black respondents also reported being able to access medical care less easily than white respondents.

Accessibility of affordable housing also presents evidence of racial/ethnic inequality for the Black community in the region. The west

side of Rockford is predominantly Black and/or low income and has been subjected to decades of structural racism and disinvestment in the community. The impacts of this are still felt today. There is a shortage of housing available to extremely low income individuals; this presents a need for additional extreme low income housing also located in closer proximity to healthcare centers and healthy food access points.

The disparities that were self-reported by the racial/ethnic survey respondents can be corroborated by observing the infrastructure in the region in relation to demographic information. For instance, the west side of Rockford is lacking in accessible healthcare locations and locations to purchase healthy food. Out of the 27 full service grocery stores in Rockford, only 5 are located in the west and south side of the city. This presents a clear issue of accessibility to healthy food options and illustrates a need for programs and services to aid this underserved community.

iv. What factors may be producing and perpetuating racial inequities associated with this issue? How did the inequities arise? Are they expanding or narrowing? Does the proposal address root causes? If not, how could it?

Physical infrastructure and a lack of wealth are some of the biggest factors. Not only are there limited healthcare, food, and other necessary facilities within the neighborhoods where most Black, Brown, and Hispanic people live, there are also limited job opportunities and lack of adequate transport to areas with jobs. Mobility is heavily constrained for these populations because of the state of the communities where they live. These inequalities arose from decades of legislated racism, institutional racism, and disinvestment from outside capital in the communities. Black households have, on average, 7.8x less wealth than white families (<https://www.federalreserve.gov/econres/notes/feds-notes/disparities-in-wealth-by-race-and-ethnicity-in-the-2019-survey-of-consumer-finances-accessible-20200928.htm#fig1>). Black, Brown, and Hispanic people in Rockford live in areas designated class D or C under redlining practices of the Home Owners' Loan Corporation (<https://dsl.richmond.edu/panorama/redlining/#loc=12/42.266/-89.098&city=rockford-il>). Residents of these communities have little opportunity being provided by outside sources and almost no ability to create any themselves due to lack of household wealth.

v. What does the proposal seek to accomplish? Will it reduce disparities or discrimination?

There is a massive access to care problem among Rockford's Black, Brown, and Hispanic populations. Most of the Black, Brown, and Hispanic communities and individuals exist on the west side of Rockford which is home to far, far fewer healthcare and healthcare-related facilities than the other parts of the city.

Our partners will each be operating to directly improve the access to healthcare within these populations. Swedish American, a Division of UW Health, in coordination with Mile Square will operate a mobile health unit which can be stationed anywhere it is needed. This will eliminate the cost of transit and problems of access to healthcare for the Black, Brown, and Hispanic populations as they will now have healthcare access as close as it is needed.

Additionally, the Rockford Housing Development Corporation's housing development will include housing within distance of Crusader Community Health facilities. The Crusader Community Health facility is a Federally Qualified Health Center, has a fully integrated urgent care and behavioral health system on site along with housing eye care, dental care, and a full Walgreens pharmacy. Creating affordable and stable housing within walking distance of this facility makes it even more able to serve the community. Black, Brown, and Hispanic families who would previously have had to travel unreasonable or impossible distances to receive even basic healthcare will have a mobile health unit deployable anywhere in their community they choose, and more people from these groups will be able to live within easy access of the Crusader Community Healthcare facility. The schedule and location of the mobile health unit will be decided jointly by the Black, Brown, and Hispanic communities and Swedish American.

Along with this, the Rockford Housing Development Corporation will also create a mixed-use development which will house an early childhood learning center with childcare, providing service to the Black, Brown, and Hispanic communities in and around the development, but also may house the relocated offices of a nonprofit that serves the population. Many of the nonprofits serving the poor, Black, Brown, and/or Hispanic populations in Rockford have their offices geographically displaced from the neighborhoods where the people they serve actually live. Adding new

locations will provide easy access and further integration into the target populations.

Through our efforts, discrimination and disparity cannot and will not be eliminated, but our projects and collaboration build on existing efforts to decrease the disparities in the Black, Brown, and Hispanic communities of Rockford and to make their neighborhoods healthier.

With more affordable housing being constructed across the street from a healthcare facility which serves anyone who enters their doors and houses a full pharmacy along with a mobile health unit which the community can choose to deploy wherever it is needed, we expect that disparities in healthcare outcomes will decrease and that access to healthcare of all kinds for the Black, Brown, and Hispanic communities will increase.

vi. What are negative or unforeseen consequences and positive impacts/opportunities for equity as a result of this proposal? Which racial/ethnic groups could be harmed or could benefit? How could adverse impacts be prevented/minimized and equitable opportunities be maximized?

The mobile health unit will primarily be staffed by existing employees of Swedish American and Mile Square. Because of the lack of access to urgent care, their hospital's emergency rooms are overcrowded and being used as urgent care by populations with limited or no access to healthcare. We can expect with almost certainty that if the staff assigned to the new efforts in the proposed collaborative are taken from the emergency room, there will be a short-term increase in wait-times.

Additionally, the data dashboard's being public-facing could fuel stigma against the west side of Rockford and its residents by making it clear just how great a disparity there is. This can be mitigated, we theorize, by always framing the health outcomes in terms of their social determinants and stressing the environmental challenges Black, Brown, and Hispanic people living in these communities face.

The van itself may also become stigmatized as it will primarily serve the Black, Brown, and Hispanic communities in Rockford's disinvested neighborhoods. Efforts to maintain a positive public image of the mobile health unit can be coordinated between the Black, Brown, and Hispanic

communities it will primarily serve and Swedish American and Mile Square who will administer and staff the mobile health unit.

vii. Are there better ways to reduce racial disparities and advance racial equity? What provisions could be changed or added to ensure positive impacts on racial equity and inclusion?

There is limited opportunity for wealth creation for residents living in disinvested neighborhoods, which are disconnected from health care, grocery stores, job opportunities, job training facilities, and institutions of higher education. All of the changes we are making are from outside uses of wealth and with companies or organizations which are not owned or controlled or beholden to the Black, Brown, and Hispanic communities.

We will ensure that the partners of the collaborative must take into consideration the wants and needs of the Black, Brown, and Hispanic communities they are serving. To accomplish this, our collaborative will take a data-informed approach driven by community input for Swedish American and Mile Square's mobile health unit in what its schedule and locations will be. There will be a working group made up of members of the Black, Brown, and Hispanic communities and those with lived experience who will coordinate with the partners of the collaborative and have a seat on the Core Team that sets priorities. Members of the collaborative who attend these meetings will also be compensated for their time at \$20/hour and be reimbursed for transportation costs or transported to the meetings at the expense of the collaborative. This is vital to ensure that those most affected, the poorest and those with least access to transit, are able to effectively lend their voices to the discussions of the collaborative.

viii. Is the proposal realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? Are there provisions to ensure ongoing data collection, public reporting, stakeholder participation and public accountability?

The data dashboard which Region 1 Planning Council will develop is a key mechanism to ensure public reporting and accountability. It will be a public-facing website showcasing current summary statistics for healthcare and social determinant statistics for the neighborhoods and populations being served, along with the progress of the collaborative's projects. Region 1 Planning Council will also be in charge of securing

data-sharing agreements with the partners to make this data dashboard as informative and sustainable as possible while protecting community and individual privacy.

As stated in our governance structure, there will be a Core Team made up of a representative from each partner of the collaborative and each working group. This Core Team will be in charge of setting priorities and ensuring compliance and ethical actions in achieving and striving toward the collaborative's goals. The Core Team has the authority to advise Region 1 Planning Council to withhold or discontinue funds to any entity they feel is not acting in best accordance with the collaboratives goals and principles. Additionally, there will be a working group made-up entirely of members of the Black, Brown, and Hispanic community in the neighborhoods our collaborative is targeting which also has the authority to advise Region 1 Planning Council to withhold or discontinue funds to any entity. These two mechanisms will ensure that the funds and efforts are being used in the best possible way to make systemic change to the populations who most need it.

The data dashboard will also help inform an annual report that will be created by RPC summarizing the progress each program and partner has made throughout the year. This report will be publicly available and advertised in local news media.

ix. What are the success indicators and progress benchmarks? How will impacts be documented and evaluated? How will the level, diversity and quality of ongoing stakeholder engagement be assessed?

Success Indicators:

Increased healthcare access from residents of disinvested neighborhoods
Increased housing access
Increased access to fresh, healthy food
Decreased emergency room visits
Improved health outcomes
Decrease shortage of housing units in the extremely low-income category
(\$0-\$16,910/annual)

Project Benchmarks:

Current Population-Level Benchmarks:

- 37 Low-income census tracts where a significant number or share of residents is more than ½ mile (urban) or 10 miles (rural) from the nearest supermarket (Source: USDA, 2019)
- 27.65 of population with low food access (MSA, Source: RRHC, 2020)
- of residents that have been to primary care provider in past 12 months, disaggregated by zip code, gender, and race/ethnicity (Source: RRHC, 2020)
- 5402 shortage of housing units in the extremely low-income category (Source: RHDC, 2021)
- 55.3% of hospital events preventable (Source: RRHC, 2020)

Current numbers for UW Swedish American's mobile integrated health program (Source: UW Swedish American)

Behavioral Health MIH:

36 patients all together have participated in the program

16 patients currently in the program

5 patients have graduated (went fully through the program)

1 patients have refused to participate in the program

2 patients have been unable to contact and have been discharged from the program

5 patients voluntarily left the program prior to completion

7 patients have been discharged from the program due to non-compliance (not following the rules of the program). Patients can be re-enrolled into the program if we have contact with them again in the ED or on the unit.

Medical MIH:

Program algorithm reinstated in April of 2021 from pull back due to COVID

For 2020 through concurrent 2021: 223 patients have been visited and outreached to

13 patients currently in the program

Several patients have declined the program over the last 2 years and or have been unreachable for follow up

5 patients have been discharges due to non-compliance

Stakeholder engagement:

We will use collaborative capacity and empowerment evaluation techniques to measure the strength of the collaboration itself, including stakeholder and community engagement. These emerging evaluation techniques have been discussed and studied in peer-reviewed journals, such as the *American Journal of Evaluation and Community Science*. Categories of evaluation include leadership and infrastructure, communications, goal-directed networks, community cross-sector partnerships, shared goals, community problem solving process, focus on equity, data use for improvement and accountability, multi-level strategies, diverse engagement and empowerment, and scale of work. These categories will be assessed on an annual basis and information will be used to inform decision making at the Core Team level.

5. Community Input

a. Service Area of the Proposed Intervention

- i. Identify your service area in general terms (e.g., "West Chicago", "East St. Louis Metro Area", "Southeastern Illinois").**

Central Northern Illinois

- ii. Please select all Illinois counties that are in your service area. (NOTE: Selecting a county does not mean that your intervention must service the entire county.)**

Winnebago and Boone County

- iii. Please list all zip codes in your service area, separated by commas**
61008, 61011, 61016, 61019, 61020, 61024, 60146, 61047, 61111, 61115,
61063, 61101, 61102, 61103, 61104, 61107, 61108, 61109, 61112, 61114,
61072, 61073, 61077, 61079, 61080, 61084, 61088, 61012, 61016, 61038,
60135, 60033, 60145, 60146, 61111, 61065, 61107, 61114, 61073, 61080

b. Community Input

Note on the importance of community input:

For collaborations to meet the real-world needs of the community members they intend to serve, it's imperative that projects be designed with community member input. We are looking for projects that engage community members in the design of the intervention

being proposed. Methods of community participatory research are encouraged.

i. Describe the process you have followed to seek input from your community and what community needs it highlighted.

In 2020, the Rockford Regional Health Council, in conjunction with the Community Health Collaborative, commissioned Region 1 Planning Council to carry out a survey: the 2020 Health Community Survey. The 2020 Healthy Community Survey received 1,677 responses from all of the survey samples combined. The survey had a mixed methodology design that included a random sample survey sent by email and a paper survey. The paper survey was distributed in Harlem and Belvidere School District 3rd grade classrooms, to the Rockford and Winnebago Housing Authorities, to Zion Development, to members of the public at 4 sites for Crusader Clinic in Winnebago County, at the Northern Illinois Food Bank's Mobile Food Pantry, and KFACT. The survey was also distributed via Facebook during the COVID-19 pandemic shutdown.

The key findings of this survey indicated that there are disparities in healthcare and food access experienced by Black, ethnic, and lower income populations present in this region when compared to white and higher income populations. The survey found access to healthcare was a chief concern. Further, white respondents were more likely to be able to access care compared to their minority counterparts. It was also found that lower income individuals in the region have a harder time accessing healthcare; nearly one in ten respondents stated that they were unable to find a provider that takes Medicaid. Another need apparent from this survey is the need for more education about medical information specifically to Black communities. It was also found that more than half of Black respondents did not trust the medical/health information they received from their provider.

Input from the community provided insight to pressing needs in regard to the relationship between health and accessibility to healthy food options. Low income areas in the project area are more likely to lack close access to locations that sell food, and have even less access to locations that sell healthy food such as grocery stores and supermarkets. For those who rely on walking and public transit, it can be difficult to reach such stores. If they are able to, there is also the issue of affordability of healthy food options. Lack of healthy food options can result in individuals becoming

overweight or obese. Of those who completed the survey, approximately half identified themselves as being either overweight or obese. This is an issue of health; according to the CDC, adults who are overweight and obese are more at risk of certain health conditions such as heart disease, stroke and kidney disease. The Nourished Neighborhoods program will serve to provide affordable and accessible healthy foods to vulnerable communities, aiming to decrease health issues and increase equitable food systems.

Overall, the community input highlights a need for more comprehensive healthcare accessibility, increased health based education and outreach, and a need for increased accessibility to healthy food options to Black, Brown, Hispanic, and low income communities to combat the health disparities that they experience. Understanding the needs of the community will aid in addressing these disparities to create a healthier community.

- ii. Please upload any documentation of your community input process or findings here. (Note: if you wish to include multiple files, you must combine them into a single document.)**

2020 Healthy Community Survey

c. Input from Elected Officials

- i. Did your collaborative consult elected officials as you developed your proposal?**

We have letters of support from Mayor of the City of Rockford, Thomas McNamara; Illinois State Senator, Steve Stadelman; Illinois State Representative Dave Vella; and Illinois State Representative Maurice West. All letters of support are attached.

- ii. If you consulted local officials, please list their names and titles here.**

6. Data Support

It is imperative that applicants use data to design the proposed work. HFS is seeking applications that are "data-first."

This means that applicants used data to determine health needs and designed and targeted the proposed work to meet those needs.

Examples of relevant data include, but are not limited to, data from the community data reports produced by UIC, data analysis of healthcare utilization data, qualitative and quantitative surveys, literary reviews, etc.

a. Describe the data used to design your proposal and the methodology of collection.

The primary source for data in formulating and guiding our collaborative's efforts was the Community Health Study, informed by the Community Health Survey. This information was supplemented by a study known as the "Strengths, Weaknesses, Opportunities, and Threats & Existing Conditions that Inform RHDC Investment Priorities in Rockford" performed by the Rockford Housing Development Corporation which provided neighborhood level data on many measures of social determinants of health.

The following were key data points which informed our decisions. Together, they paint a picture of which neighborhoods are most in need of transformative interventions to address social determinants of health.

1. There is a shortage of housing units for extremely low-income households (0-30% of the median family income of Rockford) of around 5,402 units. Because of this, there is excess strain on housing supply for the households between 30-50% of the median family income. This has resulted in higher housing costs and more doubling up for all households between 0 and 50% of the median family income in Rockford. (See attachment Figure 1a and 1b for an accompanying data visualization).
2. Rockford's west and southwest sides have the highest vacancy rates of the city. The city's total vacancy rate is around 9.74%, but this average is brought up by the incredibly high vacancy neighborhoods on the south and west sides. Neighborhoods in Rockford experiencing the highest rates of vacancy include: Ellis Heights East (30.04%); Prairie Hill/Jackson Prairie (23.93%); South Gate (21.44%); Ellis Heights West (21.21%); Signal Hill (20.83%); St. Elizabeth (19.74%); River Bluff (19.53%); and New Towne (19.09%). These high vacancy rates are indicative of historic deferred maintenance, lack of adequate household income to occupy these units, , and a lack of demand for housing overall in these neighborhoods. Unoccupied housing is a problem which will continue to worsen; units will

deteriorate and worsen density and property values of the neighborhoods. (See attachment Figure 2 for a map)

3. Most of the vacant lots in Rockford as well as most of the total vacant area is concentrated in largely the same neighborhoods as the vacant housing. (See attachment Figure 3)
4. The neighborhoods on Rockford's west and south sides are predominantly Black, Brown, and Hispanic and are home to the majority of the Black, Brown, and Hispanic communities in the city. These same neighborhoods are also home to the majority of the city's poor and have the highest poverty rates. Poverty rates for these neighborhoods are between 19.4% and 65%, well above the state and national levels of . (See attachment Figure 4a and 4b)
5. Healthcare facilities including dental, medical, behavioral health, and hospitals are even more unequally spread across the city. There are a few centrally located facilities, but one hospital, two dental, two medical, and one behavioral health facility all sit at a northern cross point for the fifth and eleventh ward. None of these facilities are located in the sixth ward. The southern part of the city appears to be without options for nearby healthcare access. Any nearby facilities (not included in this data map) are specialty care (nursing homes, rehabilitation centers, etc) or one urgent care facility -- which can be expensive, even for those who are insured. (see attachment Figure 5)
6. A composite measure for overall quality of health was constructed which consisted of a combination of: 1. Being physically unwell for at least the past 14 days, or being mentally unwell for at least the past 14 days, and not currently being insured. The west and south neighborhoods in Rockford have between a fifth and a quarter of their residents fitting this composite measure. This means that around 1 in 5 or 1 in 4 residents in these neighborhoods experiences long-term unwellness and does not have insurance to access affordable care. These rates are between double and triple the east side of Rockford. (See attachment Figure 6)
7. Much of Rockford's west side also has poor access to fresh, healthy food. There is a single full service grocery store and a comparably low rate of vehicle ownership. Many individuals in these neighborhoods rely on food available from local dollar stores, gas stations, convenience stores or food pantries (if within walking distance). (Attached are maps of USDA Food

Deserts and the locations of various food facilities in the city of Rockford: Figures 7 and 8.) Looking at the attached maps, there are clear areas of the city that have limited access to food stores. This data map identifies convenience stores and dollar stores as food sources, but those shopping options do not provide the same health and food access that a grocery store or supermarket can provide. These gaps in food access have created multiple food desert regions in the southwest area of the city and the north central neighborhoods above East State Street. There appears to be one supermarket centrally located in the southeastern part of the city, but with gaps surrounding that area that could limit access for those communities. Limited access to supermarkets and grocery stores for these communities leaves residents with limited healthy options. Even when convenience stores and small markets stock healthy foods, they are often too expensive for people with a low income to afford.

Taken together, these data points paint a clear picture: there are structure and environmental issues the Black, Brown, and Hispanic populations of Rockford are facing because of historic discrimination and the environments they live in. To actually make meaningful and lasting change to their health, intervention must be taken at the root of the issues. The social determinants of health must be the guiding principle in such transformations, and they must be concentrated on the west side of the city.

- b. Attach the results of the data analyses used to design the project and any other relevant documentation. (Note: if you wish to include multiple files, you must combine them into a single document.)**

7. Health Equity and Outcomes

- a. Name the specific healthcare disparities you are targeting in your service area, including by race and ethnicity. Describe the causes of these disparities that your project specifically seeks to address and explain why you have chosen to address these causes.**

Mile Square

The Rockford region of the service area overlaps five counties: Winnebago, Boone, Ogle, Lee, and DeKalb. Boone County is nearly 20.0% rural while Winnebago County is less than 8.0% rural. Not only are there less doctors in rural areas, but access to hospitals and specialty clinics is often nonexistent. At a rate

of 167 mental health care providers (per 100,000 population), Rockford's Boone and Winnebago Counties fall below both State (230) and National (202.80) rates.

Within Rockford, three service areas (Low-income Belvidere, Low-income Rockford West Side, and Mendota) are designated Primary Care Health Professional Shortage Areas (Primary Care HPSA), and the Whiteside/Lee-Catchment Area is a designated Mental Health HPSA designated by the National Health Service Corps (NHSC) under HRSA.

In total, 35% of the Rockford region's population is considered either low-income (20%) or in poverty (15%); both of which are higher than Cook County's averages. Twenty-six percent of the Rockford region population qualifies for Medicaid or other public insurance, which is slightly higher than in the comparison counties and well above Chicago or Cook County, demonstrating the need for safety net services. Behavioral health and addiction medicine needs are needed in Rockford as the rates of depression in adults (18.30%) and suicide (10.94) are above the State average (17.70% and 9.4% respectively). For substance use indicators, binge drinking (19.70%) and opioid-related overdose deaths (19.66%) are higher than both the State average (19.50% and 11.5 respectively) and the National average (16.20% and 12.6 respectively).

According to Syed, Gerber and Sharp (2014), over 67% of a sample population identified transportation as a barrier impacting health care access. Individuals within the Rockford region are not always able to access preventative and continued medical services due to transportation and geographical barriers. Many of the individuals affected by these systematic barriers are minorities and considered low-income. By funding this program for mobile health units, citizens of the Rockford region residing in any of the nine racially/ethnically concentrated areas of poverty (R/ECAP) will have access to preventive and continued medical services, including behavioral health services. As proven through multiple research studies, continued and managed physical and behavioral health care leads to greater individual outcomes, as well as a large return on investment within the community. Additionally, by addressing the food insecurity epidemic within these areas by partnering with the local food pantry and building community gardens, greater health outcomes will be shown through lower obesity rates and lower rates of chronic diseases such as diabetes, cancer and more. Investing in healthy food options for our community members is a central aspect of this plan, and our partners have highlighted this need as a central priority and short-term measurable goal.

8. Access to Care

- a. **Name the specific obstacles or barriers to healthcare access you are targeting in your service area. Describe the causes of these obstacles that your project specifically seeks to address and explain why you have chosen to address these causes.**

A lack of access to care presents barriers to good health. In order to decrease barriers to healthcare access in the Rockford community, the proposed project will target underserved medical populations, those with behavioral health and addiction medicine needs, those who experience housing instability and homelessness, those who experience food insecurity, and those with limited access to transportation. A major focus of the proposed project is to advance racial equity by decreasing the disparities in the Black and Brown communities of Rockford. The West-East divide of Rockford along the Rock River is real and well-known. Historically Black communities on the West Side have experienced structural racism for decades that has led to disinvestment and disparities in everything from income, to access to healthcare and health outcomes, to educational outcomes, to home values and housing conditions. As mentioned in previous sections, there are disinvested neighborhoods in Rockford with little to no healthcare facilities. These affected communities are comprised of majority Black and Hispanic residents, ultimately leaving many people of color with inadequate access to resources to protect their own wellbeing. Additionally, immediate access behavioral health and addiction appointments are sorely lacking in the Rockford community particularly when it comes to high need, under-resourced patients. Discussed in more detail in the Health Equity section, depression in adults and suicide are above the state average, while binge drinking and opioid-related overdose deaths are higher than both the state average and the national average. Another notable barrier to healthcare access in the area is transportation. Common transportation barriers include lack of a personal vehicle, transit costs, long waiting times for public transit, and long travel distances. These transportation barriers may lead to delays in clinical interventions, which ultimately result in a lack of appropriate medical treatment, exacerbation of chronic diseases, or unmet health care needs (Syed, Gerber & Sharp, 2014). Food insecurity and housing instability also act as barriers to healthcare access. According to the American Health Association, “individuals experiencing housing instability have limited access to preventive care and are more likely to have infectious diseases and chronic health conditions.” Furthermore, a study of low-income adults, found that both food insecurity and housing instability were both independently associated with barriers to health care access and high utilization of acute care (Margot et al., 2006). Individuals

who are confronted with competing demands on their limited resources may prefer addressing food and housing needs, rather than their health care needs.

b. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

One of the contributions to help in addressing barriers to healthcare would be the implementation of a mobile health unit with integrated telehealth. Miles Square Health Center (MSHC) is partnering with Swedish American to provide services via mobile health unit. As the Rockford service area has an increased need for access to health care, especially behavioral and mental health, there will be a focus on providing on-demand trauma-informed telehealth services for primary care, behavioral health and addiction to under-resourced patients. MSHC will provide a Patient Navigator (LCSW) on the van equipped with access to our Electronic Medical Records and Scheduling system (EPIC) to schedule patients for telehealth appointments with MSHC providers. MSHC providers will have open appointments on their schedules for patients on the van in order to provide services in a timely manner. If patients need or want to be seen in person, the Patient Navigator will set up an appointment for the patient, ensure that the patient has transportation to the appointment and will follow up to ensure that the appointment was completed. They will work with the patient to address any barriers that may impact their ability to attend appointments, obtain appropriate testing, or begin/continue medication management as indicated. The proposed activities will lead to an increase in the proportion of patients linked to primary, behavioral, and mental health services as well as improved compliance with medications, testing, and preventive and chronic disease health care. Providing these services in real-time will result in increased stabilization and improved access and retention in treatment for those with substance use disorders (SUD). Initiating medication assisted recovery for Opioid Use Disorder (OUD) is directly linked with a reduction in opioid overdose, infectious disease, and the morbidity and mortality associated with OUD. It also will decrease the proportion of patients seeking primary care in the emergency department or requiring admission due to untreated chronic health conditions.

In order to address housing instability and food insecurity as barriers of healthcare access, Rockford Housing Development Corporation (RHDC) will build a mixed-use building along with a yet to be determined number of affordable multifamily and single-family homes on vacant land on Rockford's west side. The site will include acreage for an urban farm to be operated under a reasonably

termed ground lease agreement. These buildings will be developed in walking distance to a Crusader Health Clinic, its walk-in services, and an onsite full-service Walgreens pharmacy. Crusader Health Clinic is a Federally Qualified Health Center, enabling it to provide necessary care to medically underserved and vulnerable populations, including the uninsured and those living below the poverty level. This will also aid in the development of a “walkable” community focusing on the ability of residents to meet daily needs without access to a car. RHDC cannot rebuild the West Side alone, but focused investment can leverage complementary resources and help provide a catalyst that residents can lean on. An effort by the proposed project to address food insecurity will be the development of The Nourished Neighborhoods program. This program will engage current and potential local urban and rural farmers, community leaders, community organizations, and policymakers to develop a strategic plan and support opportunities that engage emerging agricultural practices to address food deserts and the resulting lack of access to fresh foods.

A data dashboard with descriptions and data visualizations will track progress of various measures of healthcare outcomes, healthcare statistics, and measurements of various social determinants of health. As a result of this proposal, we expect the following measurable impacts to show progress:

- Increased number of individuals receiving early intervention services
- Increase number of individuals reached for education and awareness
- Increased number and quality of affordable housing units
- Decrease proportion of patients seeking primary care in the emergency department or requiring admission due to untreated chronic health conditions.
- Reduced chronic disease and obesity rates
- Decreased food desert designated areas
- Increase in proportion of patients linked to primary, behavioral, and mental health services
- Increased stabilization and improved access and retention in treatment for those with substance use disorders
- Improved compliance with medications, testing, and preventive and chronic disease health care

c. Why will the activities you propose lead to the impact you intend to have?

Copied and pasted this from the same section under SDOH-

The implementation of the proposed projects in these disinvested communities in the Rockford region will lead to our intended impacts for a variety of reasons. A mobile health van will help remove barriers to healthcare access these

communities and populations face such as lack of physical healthcare facilities and transportation. Additionally, research has been shown that mobile health clinics improve health literacy and self-efficacy. According to Brown-Connolly, Concha, and English (2014), patients were 78% more likely to self-manage their conditions after visiting a mobile health clinic; this led to better health outcomes, such as decreased chronic disease rates. We expect that similar results will be repeated in the communities our collaborative is targeting and for the health problems they face. Ultimately this will decrease the proportion of patients seeking primary care in the emergency department or requiring admission due to untreated chronic health conditions.

Neighborhood food system development will strengthen local food systems and aid in workforce development. The Nourished Neighborhoods program does this by focusing on supporting local food production through urban agriculture programs to grow food directly in impacted neighborhoods, while also providing job-readiness opportunities for youth and adults.

According to Healthy People 2020, "Housing instability encompasses a number of challenges, such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. These experiences may negatively affect physical health and make it harder to access health care." Housing stability in the community will be improved with the efforts by the Rockford Housing Development Corporation to increase the number and quality of affordable housing units. These units will also be within easy walking distance of a Crusader Community Health facility. Crusader operates an FQHC with full integration of their clinic into behavioral health, a full eye clinic, a full dentist, and an inhouse pharmacy operated by Walgreens. These new homes will create a community centered on the existing health facility, strengthening both the community and the facility.

9. Social Determinants of Health

- i. Name the specific social determinants of health you are targeting in your service area. Describe the causes of these social determinants that your project specifically seeks to address and explain why you have chosen to address these causes.**

The Center for Disease Control and Prevention defines social determinants of health (SDoH) as the “conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.” As mentioned in the community input section, data has revealed a clear pattern of inequality that affects communities of color and lower-income families due to the uneven distribution of investment and resources in the Rockford area. Addressing social determinants of health is of paramount importance for not only improving the health of our communities, but also for reducing health disparities that often stem from socioeconomic disadvantages.

The promotion of healthy behaviors is not enough to eliminate these health disparities. Collaboration among organizations in sectors such as transportation, education, healthcare, and housing to improve the conditions in the environment is vital to improving health outcomes. Winnebago County is currently 90th of our 102 Illinois Counties for Health Outcomes and 91st for Health Factors (County Health Rankings, 2021). When looking at Rockford, being able to understand how access to healthy food, quality healthcare, community facilities, and safe housing is impacting its communities, allows us to better understand and address these issues to provide a more equitable future for all. The proposed plan will collaborate with partner organizations to focus on five social determinants of health that have risen to the top of local priorities as surveys and community discussions reveal disparities across various health outcomes and communities. The SDoH of focus are the following:

1. Healthcare access
 - a. Recent data from the Rockford Housing Development Corporation shows that the majority of healthcare facilities exist in the northeast quadrant of Rockford. There are a few centrally located facilities, but one hospital, two dental, two medical, and one behavioral health facility all sit at a northern cross point for the fifth and eleventh ward. None of these facilities are located in the sixth ward. The southern part of the city is without options for nearby healthcare access. Other nearby facilities are specialty care (nursing homes, rehabilitation centers, etc.) and a single urgent care facility. There are major gaps in access to care in Rockford, leaving entire communities without healthcare options nearby which can impact an individual's healthcare needs, including access to emergency care, ongoing chronic care, and primary or preventative medical care.
2. Food security
 - a. A USDA study found census tracts that are food deserts tend to have smaller populations, higher rates of abandoned or vacant homes, and residents with lower levels of education, lower incomes, and higher

unemployment. Census tracts with higher poverty rates are more likely to be food deserts than otherwise similar low-income census tracts in highly populated urban areas (USDA, 2012). This is certainly true in Rockford with its 22% poverty rate. Further impacting aforementioned social and economic struggles, many neighborhoods in Rockford lack access to fresh food and experience food insecurity. The USDA Food Atlas map indicates that almost 13,000 people in nine census tracts in Rockford are both low income and have low access to food, defined as being greater than one mile from the nearest full-service grocery store (USDA, 2021). While Rockford has approximately 27 full access grocery stores, they are concentrated on the east side. The south and west Rockford areas have only five full access grocery stores (Erikson Institute). Residents who live in the southwestern part of the city are further from a supermarket and in more cases are without a vehicle to access the store. Between 25-59% of housing units in southwestern neighborhoods are without a vehicle and are beyond a half-mile from a supermarket (USDA Food Access Research Atlas Data, 2019) That percentage drastically decreases the more north and east you move across the city. The draft Human Services Transportation Plan RPC produced in 2021, found that although transit does connect neighborhoods to supermarkets, service is often inefficient or doesn't come frequently.

3. Transportation

- a. According to the Mile Square Health Center Needs Assessment, respondents from the Rockford area reported lack of transportation to be a major barrier to accessing care. In only two Rockford zip codes do 3% of the population travel to work via public transportation, and public transit is only available in the immediate region of the city of Rockford. Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use. These consequences may lead to poorer management of chronic illness and thus poorer health outcomes (Syed, Gerber & Sharp, 2014). Understanding the relationship between transportation barriers and health is important in addressing health in the most vulnerable.

4. Housing

- a. A draft SWOT analysis produced by the Rockford Housing Development Corporation (2021) found a severe shortage of affordable rental units for extremely low-income households (0-30% Median Family Income or MFI) in Rockford. While there are 8,072 households within the <30% MFI income bracket, there are only 2,670 units in the city that are affordable to households in that income group, resulting in a shortage of 5,402 units. This shortage also has spillover effects on 30-50% MFI households, who

technically have adequate housing supply but must compete with 0-30% households for that same supply. Overall, the analysis found that extremely low income and very low income households are forced to compete with households of all incomes for housing that is out of their price range. Additionally, for those who have secured a unit with the Rockford or Winnebago Housing Authority, there are too few quality options to take the next step as their income rises.

5. Workforce development

- a. The Rockford region has been known for decades as a manufacturing hub with a skilled trade workforce. While much of the workforce remains in the area, the movement of industries to other locations and lack of state support for manufacturing has reduced the number of trades jobs available in the area. Rockford residents have an 84% high school graduation rate and 22% of the population has a bachelor's degree or higher (far lower than the state of Illinois at 35%). Historical and current employment trends, including recent increases in unemployment due to the COVID-19 pandemic, have kept Rockford's unemployment numbers high. In preliminary data from the US Bureau of Labor Statistics, the Rockford metropolitan statistical area had an unemployment rate of 9.5% in June 2021 – the national average at the time was 5.9%. Winnebago County, which surrounds the City of Rockford, is highly rural with over 700 farms and 1,000 farmers. However, resources for urban farmers are limited and scattered across a variety of organizations. Based on the unemployment rates and educational attainment, there are opportunities for urban agriculture to fit community needs for accessible new jobs. Rockford's manufacturing history developed a workforce with strong hands-on skills, making training or retraining in urban agriculture and food system jobs a logical switch for residents.

ii. What activities will your collaborative undertake to address the disparities mentioned above? What immediate, measurable, impacts will follow from these activities that will show progress against the obstacles or barriers you are targeting?

- Mobile health unit with integrated telehealth (PCP/behavioral health)
 - A mobile health van integrating primary care and behavioral health using telehealth services provided by Swedish American Health Systems and Miles Square will be deployed to neighborhoods that have been identified as at-risk. The van addresses the built environment, specifically housing insecurity and economic instability, by traveling to patients in the community

to provide outreach and referral. Every patient receives an intake questionnaire that includes questions focused on social determinants of health, including the patient's living conditions, food access, benefits, transportation, and preferred means of communication. More specifically, if transport is an issue for a patient, the Patient Navigator will assist in setting up transportation via the patient's insurance and if needed, MSHC will provide transportation support (Public bus cards/LYFT/Uber). Additionally, assistance will be provided to patients with food insecurity in obtaining access to food pantries. If a patient's living conditions are unstable, the Patient Navigator can provide a list of safe shelters and MSHC's social work aide can assist with housing applications. The Patient Navigator can also assist with any matters regarding a patient's insurance, including assistance in health insurance applications. Furthermore, providers participating in the project are equipped with the knowledge and resources to address trauma as a root cause of health inequity and all patients will be provided with services that reflect these values.

- Neighborhood food system development
 - Gaps in food access have created multiple food desert regions in Rockford's disinvested neighborhoods.. Limited access to supermarkets and grocery stores for these communities leaves residents with limited options for healthy food. Even when convenience stores and small markets carry healthy foods, they are not affordable for low-income households. Additionally, there is currently no community-wide plan for the maintenance of existing urban gardens or for the growth of new urban agriculture projects. Training and educational opportunities for agriculture are also limited. The proposed Nourished Neighborhoods program aims to fill that gap and fulfill the need for a centralized coalition for urban agriculture resources in Rockford because everyone deserves access to fresh, healthy food. Moreover, it will do so in a way that incorporates underserved community voices in the creation of strategy and plans to address the lack of access to fresh foods. This program will focus on supporting local food production through urban agriculture programs to grow food directly in impacted neighborhoods, while also providing job-readiness opportunities for youth and adults. Secondly, Nourished Neighborhoods will address food distribution and systems change through education and outreach. Lastly, the Nourished Neighborhoods Program will promote the use of green space to benefit mental and physical health. By creating programs for community gardens and other hands-on, food-centered activities, those involved will benefit from nutritious, healthy foods, physical activity, and social cohesion. This all helps to improve preventative health measures and thus the health of the Rockford region.

- Housing development using SDOH framework
 - Rockford Housing Development Corporation will build a mixed-use building, containing second floor multifamily affordable apartment units over commercial space along with a yet to be determined number of multifamily and up to 5 single-family homes annually beginning the second year of the project, constructed by Habitat for Humanity, on vacant land on Rockford's west side. As a means to improve food security, the site includes acreage for an urban farm to be operated under a reasonably termed ground lease agreement. A "free community garden" will also be included to ensure all residents have access to fresh and healthy food for much of the year. Residents living near the site will be encouraged to participate in the farming/gardening program as well as in learning how to best cook healthy food through occasional on-site cooking pop-up demonstrations, and neighbor block parties that encourage community involvement. Furthermore, local non-profits that carry out intensive work in Rockford's disinvested neighborhoods but lack dedicated physical space in the community will be encouraged to relocate their offices to the open commercial spaces on the first floor of the mixed-use buildings. The commercial space will also include the return of CeaseFire (now Cure Violence) to address youth gun violence (prevalent in the neighborhood and community).

Cure Violence is an organization that previously had a successful operation in the City of Rockford but closed its doors after losing support from a prior Rockford City Police Chief. The National Gang Center (NGC) rates Cure Violence as a comprehensive promising practice intervention for gang involved youth and adults. The hope is that with the new space, RHDC would hold some office space with the intention of leasing it to them at a favorable rate. The BHPTNT Collaborative would convene with the organization to convince them to return and demonstrate to them the benefits of doing so. In addition to the social services office spaces, a child/day care center and appropriate playground and outdoor space will be included to address the lack of childcare facilities on the west side. Quality, affordable, and convenient childcare was one of the most mentioned resident impediments to maintaining employment. The social determinants of health guide all RHDC planning and implementation options.

The plot of land and vacant infill lots, are within walking distance of the Crusader Health Clinic, its walk-in services, and onsite full-service pharmacy. Crusader Health Clinic is a Federally Qualified Health Center,

enabling it to provide necessary care to medically underserved and vulnerable populations, including the uninsured and those living below the poverty level.

iii. Why will the activities you propose lead to the impact you intend to have?

The implementation of the proposed projects in these disinvested communities in the Rockford region will lead to our intended impacts for a variety of reasons. A mobile health van will help remove barriers to healthcare access these communities and populations face such as lack of physical healthcare facilities and transportation. Additionally, research has been shown that mobile health clinics improve health literacy and self-efficacy. According to Brown-Connolly, Concha, and English (2014), patients were 78% more likely to self-manage their conditions after visiting a mobile health clinic; this led to better health outcomes, such as decreased chronic disease rates. We expect similar results will be repeated in the communities our collaborative is targeting and for the health problems they face. Ultimately this will decrease the proportion of patients seeking primary care in the emergency department or requiring admission due to untreated chronic health conditions.

Neighborhood food system development will strengthen local food systems and aid in workforce development. The Nourished Neighborhoods program does this by focusing on supporting local food production through urban agriculture programs to grow food directly in impacted neighborhoods, while also providing job-readiness opportunities for youth and adults.

According to Healthy People 2020, "Housing instability encompasses a number of challenges, such as having trouble paying rent, overcrowding, moving frequently, staying with relatives, or spending the bulk of household income on housing. These experiences may negatively affect physical health and make it harder to access health care." Housing stability in the community will be improved with the efforts by the Rockford Housing Development Corporation to increase the number and quality of affordable housing units. These units will also be within easy walking distance of a Crusader Community Health facility. Crusader

operates an FQHC with full integration of their clinic into behavioral health, a full eye clinic, a full dentist, and an inhouse pharmacy operated by Walgreens. These new homes will create a community centered on the existing health facility, strengthening both the community and the facility.

10. Care Integration and Coordination

The overarching goal of Miles Square Health Services is to provide high-quality, evidence-based wrap-around care, decrease inequity, reduce recidivism, reduce ED/hospital admissions for chronic disease management, substance use and severe mental illness related events, and other poor health outcomes. The traditional treatment model where patients are directly referred to primary care and behavioral health services at a later date does not meet the needs of residents in Rockford's disinvested neighborhoods. This traditional model does not immediately address patients' needs at time of presentation especially as these patients often present in crisis. Few patients referred actually present for care for follow-up services if no services are given on the day of presentation. Through an integrated primary care behavioral health approach, our Patient Navigator, a licensed clinical social worker (LCSW) will evaluate patients in real time during an interaction in the van and connect the patient to medical services through tele-health on the same day. This multi-modality of evaluation and support will help overcome some of the barriers patients face when needing immediate assistance for a medical or behavioral health concern.

A collaboration between the Swedish American Hospital and MSHC will establish a model of care coordination serving those with medical and behavioral health needs in the Rockford community. Expansion will include providing an existing Patient Navigator who is an LCSW on a mobile unit who will perform social determinants of health assessment, behavioral health assessment, motivational interviewing, and link patients to telehealth appointments with MSHC primary care, substance use and/or behavioral health providers. The Patient Navigator will assist patients in identifying additional barriers such as transportation and medication access through their intake assessment and assist through transportation vouchers, working with our pharmacy for medication access under the 340B program, and working with the patient's insurance

The Patient Navigator (LCSWs) on the van will be the case manager to help link the patient with the appropriate medical services that may best fit that patient's condition. On the van, the Patient Navigator will touch base with the

patient to assess if any barriers stand in the way of obtaining care. The linkage provided will include assisting the patient in scheduling an initial appointment with the appropriate provider via telehealth and then additional follow up appointments. A follow up phone call will be made by the Patient Navigator to follow up if the patient was able to attend the in-person appointment (if applicable). If the navigator is unable to reach a patient, they will attempt to follow up with the patient at minimum three attempts within a 2-week period. If a patient is unable to be reached and a message cannot be left, a letter will be sent to the patient's address with the BHC and MSHC contact information.

a. Describe how your proposal improves the integration, efficiency, and coordination of care across provider types and levels of care.

Care integration and coordination will be improved through mobile health solutions and housing development. The mobile health unit partnership between UW Health and Mile Square, working in tandem with a managed care provider, includes telehealth integration that allows for individuals to access behavioral health and medical care from their neighborhood. Referrals will also be made to connect residents with other specialists in the systems as needed. Furthermore, by proactively reaching out to residents in disinvested neighborhoods where dependency on emergency care is high, this proactive approach will reduce the dependency on the nursing home and increase utilization of primary care and behavioral health in an outpatient setting, reducing the cost of care overtime.

The development of low-income housing adjacent to an FQHC that has primary care and behavioral health integrated with an urgent care model is also extremely important to improving health access and reducing emergency room dependence. The co-location of non-profit agencies who serve residents in this geographic are at the mix-used housing development further increased the degree of service delivery integration and coordination.

b. Do you plan to hire community health workers or care coordinators as part of your intervention?

Yes, the functions of the medical practitioners in the mobile health unit include community health and outreach. Social workers are also part of this proposal to assist with care coordination for behavioral health.

c. Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable).

The benchmark numbers for the Behavioral Health Mobile-Integrated Health at Swedish American (UW Health) , which focuses on super-utilizers of the emergency room are as follows: 36 patients have participated in the program, 16 patients are currently enrolled, 5 patients have graduated, 1 patient refused participation, contact was lost with 2 patients, 5 patients voluntarily un-enrolled from the program, and 7 patients have been discharged from the program due to non-compliance. These patients are permitted to re-enroll if contact is established. Under this model, the program shows a total financial impact (or cost savings) of \$100,480.96 over a seven month period due to reduced Emergency Room visits. Deducting salary and fringe benefits costs from that, the overall savings was \$42,676.14 shared across a multitude of managed care providers and the State of Illinois.

We anticipate a significant increase in these numbers with the mobile health unit which will focus on geographic areas with high morbidities and not solely super-utilizers. While the cost savings for each individual case might be lower on an individual basis, we anticipate overall system cost savings to increase on the basis of reaching a higher number of individuals who are at risk of becoming super-utilizers with chronic health problems.

- d. Are there any managed care organizations in your collaborative? Molina Healht is not a direct partner of the collaborative, but has an MOU with UW Health to participate in and cost-share on the Mobile Health Unit.**
- e. Please list the names of the managed care organizations in your collaborative. N/A**
- f. If no, do you plan to integrate and work with managed care organizations? Yes.**
- g. Please describe your collaborative's plans to work with managed care organizations. We intended to work in partnership with Molina Health on mobile health solutions and data analysis to show the health care costs savings associated with mobile health units.**

11. Minority Participation

- a. Please provide a list of entities that will be a part of your collaboration/partnership that are certified by the Illinois Business Enterprise Program (BEP) and/or not-for-profit entities majorly controlled**

and managed by minorities that will be used on the project as subcontractors or equity partners.

Note on BEP partners/vendors:

If one of the members of your collaboration already contracts with a BEP-certified firm or a not-for-profit entity that is majorly controlled and managed by minorities, only include the services of the firm that will be used on this project.

To be included, these services must increase the entity's volume of work above the level of services already provided to the collaborating member.

Resource to help you search for/identify BEP-certified vendors in Illinois: If you are seeking BEP-certified entities to partner/collaborate with, you may consult our resource guide linked below on How to Look Up BEP-Certified Vendors in the State of Illinois.

Led by Executive Director Becky Cook Kendall, the Rockford Regional Health Council is a local non-partisan organization focused on improving our region's health through data gathering and analysis, education, and advocacy. As a collaboration of healthcare, business, and community, the Council acts as a catalyst for the development and implementation of an affordable, high quality health care system throughout Boone and Winnebago Counties.

The Council also ensures that all community needs and issues are assessed through the triennial Healthy Community Study. This leads to a higher quality of life by direct changes to strategic planning, program development, and funding.

- b. Please describe the respective role of each of the entities listed above, and specify whether they will have a role only during the implementation of your proposal or if they will have a role in the ongoing operation of your transformed delivery system**

The role of the Rockford Regional Health Council in this proposal will be to coordinate with RPC on the Healthy Community Study and its findings. As a process of gathering, analyzing, and reporting information about current community conditions, it identifies trends and priorities in the health status of our region. RPC and the Rockford Regional Health Council will work as a comprehensive research hub that gives local government, business, education, non-profit, and healthcare entities an opportunity to create and implement strategies that improve these conditions.

12. Jobs

a. Existing Employees

- i. **For collaborating providers, please provide data on the number of existing employees delineated by job category, including the zip codes of the employees' residence and benchmarks for the continued maintenance and improvement of these job levels.**

Region 1 Planning Council (RPC):

Intergovernmental and Executive Relations (1% FTE)

This role is already filled at RPC. This individual handles meetings involving high-level executives, CEOs for organizations both in and outside the BHPTNT Collaborative, and press conferences.

Director of Community Impact (20% FTE)

This role is already filled at RPC. This individual will attend and help facilitate stakeholder meetings, funder meetings, and maintain adherence to the vision and goals of the BHPTNT Collaborative. They will function as a liaison for community engagement, coordinate with any legal or data departments with agencies of the fiscal agent, and develop and oversee contracts and subawards.

Communications Specialist (5% FTE)

This role is already filled at RPC. This individual will handle branding, assist with community engagement, social media presence, press conferences and relations, and planning community events.

Accountant (5% FTE)

This role is currently filled at RPC. This individual will assist with financial reports, procurement, maintain financial records, and issue payments for any subawards that flow through the fiscal intermediary.

Sustainability & Resilience Coordinator (25% FTE)

This role is currently filled at RPC. This individual will manage the food systems specialist, a new hire, and will attend and help facilitate stakeholder meetings, funder meetings, and maintain adherence to the vision and goals of the BHPTNT Collaborative. They will also function as a liaison for community engagement, coordinate with any legal or data departments with agencies of the fiscal agent, and develop and oversee contracts and subawards. Their focus is the food system aspect of the BHPTNT Collaborative.

Environmental Planner (30% FTE)

This role is currently filled at RPC. This individual will help with the planning work in coordination with the Community Health Improvement Plan and Community Health Needs Assessment.

Swedish American

Mobile Health Unit RN Coordinator

Coordinate with staff and partners the operations of the mobile unit and medical practitioner for the mobile health unit.

Advanced Practice Registered Nurse

Medical practitioner and health educator for mobile health unit.

Medical Doctor

Medical practitioner and health educator for mobile health unit.

Administrative Assistant

Assist coordinate with staff and partner coordination for mobile health unit operations.

Mile Square Health Center:

Patient Navigator

One (1) individual will set up appointment(s) for the patient, ensure that the patient has transportation to the appointment and will follow up to ensure that the appointment was completed. They will work with the patient to address any barriers that may impact their ability to attend appointments, obtain appropriate testing, or begin/continue medication management as indicated. Patient Navigator can also assist with any matters regarding a patient's insurance, including assistance in their health insurance applications. The individual will be a full-time employee (1.0 FTE) of Mile Square Health Center with an annual salary of \$70,000. This grant will cover 100% of their salary and benefits for the first 3 years and decrease by 5% in year 4 and another 5% in year 5.

Program Manager

1 individual will develop high-risk registries from the EPIC Electronic Health Record (EHR) patient registries to support the identification of patients with serious illnesses and assist with transitions of care. They will assess social determinants of health to inform primary care and mental health services. The Project Coordinator is a full-time employee (1.0 FTE) of Mile Square Health Center with an estimated annual salary of \$49,000. This grant will cover 50% of their salary and benefits.

Social Worker

One (1) individual will provide crisis intervention, trauma informed counseling, and case management for patients in the Rockford region. They will work in tandem with our current BHCs to ensure coverage of extended hours, immediate access, and case management services. They will be responsible for tracking the program deliverables. They will be supervised by our Clinical Psychologist in-person or by phone during hours of coverage. They will be Full-Time employees (1.0 FTE) of Mile Square Health Center with an annual salary of \$70,000. This grant will cover 20% of their salary and benefits annually for 5 years.

Community Health Worker

One (1) individual will be recruited from the Rockford community area to provide community and clinical support. The Community Health Worker will have emphasis on the community areas of the Rockford region. They have increased outreach and connection to services to meet basic needs such as food insecurity. They will work closely with Mile Square Health Center and Swedish American. The Community Health Worker will provide community based education and support on prevention, testing options and general education and support. This individual will be a full-time employee (1.0 FTE) of Mile Square Health Center with an annual salary of \$48,154. This grant will cover 25% of their salary and benefits for year 1 and decrease by 5% annually.

Clinical Physician

Two (2) individuals will have open appointments on their schedules for patients on the van in order to provide services. providers will continue routine primary care visits and expand the use of telehealth to support virtual assessment and home monitoring, as well as continuing routine primary care visits. The individuals will be full-time employees (1.0 FTE) of Mile Square Health Center with an annual salary of \$180,000. This grant

will cover 25% of each of their salaries and benefits for year 1 and decrease by 5% annually.

Psychiatry Advance Practitioner

This individual will provide e-consults and direct patient care for adults and pediatric patients regarding diagnosis, medication management, and higher levels of care on the mobile van. The individual will be full-time employee (1.0 FTE) of Mile Square Health Center with an annual salary of \$110,000. This grant will cover 25% of their salary and benefits for year 1 and decrease by 5% annually.

*Swedes is using all existing employees - check their budget spreadsheet
Mile Square has specific positions that may be filled internally or externally*

RPC

In all cases, entities will prioritize candidates within the neighborhoods being targeted by our collaborative's efforts

b. New Employment Opportunities

i. Please estimate the number of new employees that will be hired over the duration of your proposal.

New Hire : Program Coordinator (40% FTE)

This coordinator is a new hire who will supervise staff at RPC assigned to the collaborative's work. They will attend and help facilitate stakeholder meetings and coordinate oversight and project management with the Director of Community Impact.

New Hire : Grant Specialist (75% FTE)

The grant specialist is a new hire. The grant specialist will manage compliance of the BHPTNT Collaborative, manage sub-awardees, connect with BHPTNT partners to review and maintain fidelity and adjust timelines, communicate with the funder, oversee performance reporting, coordinate with the fiscal agent on financial reports, convene and administer the Core Team and its meetings along with any Working Groups that require such assistance.

New Hire : Data Associate (50% FTE)

The data associate is a new hire. This individual will support another new hire, the data specialist, oversee data entry, support survey development,

support development of data agreements with partners, support development and maintenance of the data dashboard, and conduct research for the Community Health Improvement Plan and Community Health Needs Assessment--two large research efforts which culminate in documents outlining the needs of community health and the plans to improve it.

New Hire : Data Specialist (20% FTE)

The data specialist is a new hire. This individual will oversee another new hire, the data associate, oversee survey development, oversee development of data agreements with partners, oversee development and maintenance of the data dashboard, and conduct research for the Community Health Improvement Plan and Community Health Needs assessments--two large research efforts which culminate in documents outlining the needs of community health and the plans to improve it.

New Hire : Public Health Planner (50% FTE)

The public health planner is a new hire. This individual will conduct research for the Community Health Improvement Plan and Community Health Needs Assessment. They will also manage project planning, support mobile health solutions staff with any research related to their program or health in the BHPTNT collaborative's goals, and research that is needed to maintain project fidelity.

Food Systems Specialist (100% FTE)

To support the Nourished Neighborhoods Program, RPC will hire a Food Systems Specialist and Project Assistant. The Food Systems Specialist will be responsible for actively engaging and facilitating collaboration with key local food system partners and stakeholders to plan, develop, and coordinate activities. This includes the development of the Nourished Neighborhoods Coalition. The Food Systems Specialist will assist with building the strategic framework of the Nourished Neighborhoods Program, which includes creating an inventory of available land to support local food production, identifying the most vulnerable communities, and prioritizing which areas to address first. The product of this analysis will be included in the Community Health Needs Assessment and Community Health Improvement Plan. The Food Systems Specialist will also perform public outreach, attend events, and facilitate the creation of educational programs to build a vibrant, inclusive, and resilient local food economy.

Program Associate (100% FTE)

The Program Associate will be responsible for assisting the Food Systems Specialist in the implementation of these programs. These tasks will include a range of project and planning activities including data collection, research, analysis, writing, facilitation, and partner and community engagement support. With these positions, the Nourished Neighborhoods Program will be able to build capacity to revitalize the local food system, ensuring each community has access to fresh, healthy foods regardless of other factors.

Interns (200% FTE)

Assist full-time staff with duties as assigned. Participation at community engagement events.

- ii. **Describe any new employment opportunities in the future alignment of your proposal and how those opportunities reflect the community you serve**

Mile Square sent this:

Two new employees will be hired- a Patient Navigator (LCSW) and a Psychiatry/Family Med PA or NP

- iii. **Please describe any planned activities for workforce development in the project**

The 2 FTE interns that RPC will hire will be trained and given work experience in the healthcare system for the Rockford Region. RPC, and the rest of the partners, will prioritize hiring people from within the communities the BHPTNT intends to serve.

13. Quality Metrics

Note: Once metrics are agreed upon in the negotiated funding agreement, HFS will proceed to establish a baseline for the service community, a tracking process, and negotiated improvement targets.

- a. **Alignment with HFS Quality Pillars**

HFS Quality Strategy:

<https://www.illinois.gov/hfs/SiteCollectionDocuments/IL20212024ComprehensiveMedicalProgramsQualityStrategyD1.pdf>

i. Tell us how your proposal aligns with the pillars and the overall vision for improvement in the Department's Quality Strategy.

The Mobile Health Unit aligns most to the third, fourth, and fifth pillars of the HFS Quality Strategy vision for improvement--Improve Behavioral Health Services and Supports for Children, Increase Preventive Care Screenings—Use Data to Identify Target Areas in Priority Regions where Disparities in Optimal Outcomes are the Highest, and Serve More People in the Settings of Their Choice. The unit will be able to be driven to whatever neighborhood or community needs it, increasing access of seniors and others with limited mobility and transit options. By having primary and preventative care able to be brought to the community rather than them having to go to it, there will be increased independence of individuals.

Additionally, transit costs are one of the biggest barriers to healthcare for the poorest and most discriminated-against groups. These communities of Black, Hispanic, and other minority groups face the largest disparities in our region and have the most limited access to care. There are few doctor's offices or other healthcare facilities in their communities--with a shockingly low amount on the west and south west sides of Rockford. With a mobile health unit, this barrier can be partially addressed. The community will be able to give input into where the mobile health unit will travel so as to best serve them.

Additionally, the housing development to be built on a brownfield site by the Rockford Housing Development Corporation aligns with the fourth pillar of the vision for improvement as well. Crusader Health has a facility on the west side of Rockford which can take primary and urgent care patients and houses a full-service pharmacy within its building. The Rockford Housing Development Corporation will build numerous new single family homes within walking distance of, creating a new neighborhood where the residents can easily access multiple forms of healthcare without the need for any sort of costly transit. The housing development will also feature a daycare and early childhood center housed on the first floor of a mixed-use building that will be part of the same lot, increasing access to childcare for both residents of the new development and existing residents of the area. There will also be office space in the mixed-use building where local non-profits will be encouraged to relocate to bring them closer to and better able to serve residents in the

neighborhood.. Depending on which organizations occupy this space, there is great potential for substantial improvement to transitions for inpatient care to community-based services for the neighborhood. Crusader can provide child visits in house at their facility, immunize children and adults. (integrate this into the rest of the paragraph and then rewrite the whole thing. This is word soup of ideas atm)

b. Does your proposal align with any of the following Pillars of Improvement?

i. Maternal and Child Health?

- 1. Maternal and Child Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

ii. Adult Behavioral Health?

- 1. Adult Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

- Increase in proportion of patients linked to primary, behavioral, and mental health services
- Initiating medication assisted recovery for opioid use disorder is directly linked with a reduction in opioid overdose, infectious disease, and the morbidity and mortality associated with Opioid Use Disorder

iii. Child Behavioral Health?

- 1. Child Behavioral Health: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**
NO????

iv. Equity?

- 1. Equity: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

- Increase access to services for primary care, behavioral health and addiction to under-resourced patients

v. Community-Based Services and Supports?

- 1. Community-Based Services and Supports: Propose measurable quality metrics you propose to be accountable for improving. You should choose at least one metric from the quality strategy.**

c. Will you be using any metrics not found in the quality strategy?

i. Please propose metrics you'll be accountable for improving and a method for tracking these metrics.

- Increase the number of people who live within walking distance to a location that sells fresh food by establishing food pantries and additional healthy food resources in food deserts in the region. Progress to be tracked by analyzing census tracts relative to the location of full service grocery stores.
- Increase the number of community gardens and other urban agriculture in food deserts.
- The number of people who participate in educational efforts.
- Measure the amount of food in pounds that is grown in community gardens and given to members of the community who are in need of healthy food.

14. Milestones

- a. For all activities described in your proposal, please provide a calendar of milestones to show progress (e.g., when IT will be purchased, when IT will be operative, when construction projects will begin and end, when people will be hired, etc.) The timeline should be in months from award**

A calendar detailing the milestones of progress of our proposal is attached to this application. Milestones are separated into sections based on the activity they are tracking progress for.

15. Budget

- a. Annual Budgets across the Proposal**

In order to fill out budgets correctly, please view these technical video instructions for completing a budget.

Use the Excel template below to list the line items of your budget. Working within one single Excel file, fill out sheets for each year that you are requesting funds.

Please check that all totals are correctly calculated, especially if you have added new rows to the spreadsheet.

Applicants are responsible for submitting accurate totals. Note: This spreadsheet has been locked, but not password protected.

Some aspects of your budget request may be funded out of state capital dollars and not transformation funds. HFS will make decisions on funding source. Include all expenses for which you seek reimbursement in your budget regardless of funding source

NOTE: Your budget should demonstrate a clear ramp down of reliance on Transformation funding and a ramp up of reimbursements for services and other funding sources that show sustainability over time.

When completed, please upload your spreadsheet here.

- b. Number of Individuals Served**
 - i. Please project the number of individuals that will be served in each year of funding.**
- c. Alternative Payment Methodologies**
 - i. Outline any alternative payment methodologies that your proposal might utilize for receiving reimbursement for services from MCOs.**

16. Sustainability

- a. Include a narrative that describes how your budget will decrease reliance on Transformation funding over time and how reimbursements for services and other funding sources will increase and establish sustainability over time. (i.e. how will your project continue to operate without HTC funding?)**
- b. In particular, include how services that address social determinants of health will be funded on an ongoing basis (for example, through existing**

payment models, alternative payment methodologies for Medicaid services, or through other funding sources).

The benchmark numbers for the Mobile-Integrated Health at Swedish American (UW Health) , which focuses on super-utilizers of the emergency room are as follows: 36 patients have participated in the program, 16 patients are currently enrolled, 5 patients have graduated, 1 patient refused participation, contact was lost with 2 patients, 5 patients voluntarily un-enrolled from the program, and 7 patients have been discharged from the program due to non-compliance. These patients are permitted to re-enroll if contact is established. Under this model, the program shows a total financial impact (or cost savings) of \$100,480.96 over a seven month period due to reduced Emergency Room visits. Deducting salary and fringe benefits costs from that, the overall savings was \$42,676.14 shared across a multitude of managed care providers and the State of Illinois.

The homes built and sold via the RHDC will be sold at affordable rates to members of the public. The sales from these homes will be put back into the construction budget to continuously build more homes. The rents charged on the apartments in the mixed use section will

The services provided by Region 1 Planning Council will not be needed after the grant's 5-year funding period. The role of RPC's staff is to set up and monitor the development and implementation of the collaborative's goals. Therefore, RPC's responsibilities in the proposed project do not require continuous funding.

c. In your narrative, highlight any key assumptions that are critical to making your project sustainable.

Multiple components of the proposal require initial funding to become established but will see lower maintenance and persistent costs thereafter. For instance, initial construction costs associated with the proposed affordable mixed-use housing unit to be located near Crusader Clinic are far more significant compared to the lower cost of building maintenance. The construction of affordable housing will also financially sustain itself, as profits earned from selling houses can be used to fund construction of additional houses.

In the case of Swedish American, they are engaging in cost sharing for the proposed mobile health units. This indicates that these units will be saving them

costs elsewhere. The mobile health units are expected to reduce the amount of expensive ER visits and other costly uses of healthcare.



Mile Square Health Center
1220 South Wood Street (MC698)
Chicago, IL 60608

November 16, 2021

To Whom it May Concern:

I am committed to the partnership between UI-Mile Square Health Center (UI-MSHC) and Swedish American (a division of University of Wisconsin Health) for the collaborative project entitled: Building Healthy Places Through Neighborhood Transformation (BHPTNT).

UI-MSHC is a Federally Qualified Health Centers (FQHC) operating 14 different sites, providing comprehensive, high quality health services through the continuum of care (primary, preventative and specialty care, women's health, vision and dental care). MSHC was initially established in 1967 to address the needs of Chicago's public housing residents. Since then, nearly 40,000 patients (74% African American and 21% is Latino) call UI-MSHC their medical home. Approximately 99% of our patients are at or below 200% of the poverty level and over 75% have public insurance. Uniquely, UI-MSHC is one of the few FQHCs in the nation embedded in a public university. In May 2019, UI-MSHC established its site in Rockford Illinois. The UI-MSHC L.P. Johnson clinic as it is known, has become an important healthcare contributor in the community as reflected by the broadening of clinical service offerings to the Rockford community and growth that the practice has experienced in capacity (new service options- behavioral and dental care) and volume. As a FQHC, UI-MSHC serves all patients regardless of ability to pay or citizenship status.

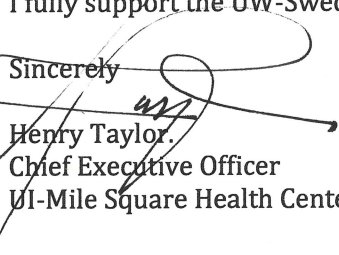
UI-MSHC pledges to adhere to collaborative policies and agrees to honest dealing, acting prudently, ethically, and in good faith regarding the collaborative of which it is a part.

Program Overview: The Mobile Health Unit (MHU) program will consist of a dual approach that will include stationary events in targeted communities as well as mobile prevention programs designed to reach rural impact areas. The MHU will be operated by Swedish American hospital, a division of UW-Health. A UI-MSHC patient navigator on the van will provide service linkage to newly engaged patients through tele-health or with scheduled future in person clinic appointments. The MHU will deliver preventive and primary care to communities in Rockford currently facing healthcare outcome disparities with the goals of improving health outcomes and decreasing the financial burden the residents of these communities place on the healthcare system at large. UI-MSHC will also coordinate with the Region 1 Planning Council to provide de-identified data on the communities it is serving, pending an institutionally approved data share agreement, so the Region 1 Planning Council can create and update a data dashboard to inform the collaborative.

Hours and Staffing: UI-MSHC will commit the funded and agreed upon staff resource to the MHU. This staff includes: a patient navigator, a social worker, a psychiatry advance practitioner, a community health worker, a program manager, clinical physicians.

I fully support the UW-Swedish American and UI-MSHC collaborative for the BHPTNT project.

Sincerely


Henry Taylor,
Chief Executive Officer
UI-Mile Square Health Center



November 12, 2021

RE: Illinois Healthcare Transformation Grant Commitment

To Whom it Concerns:

Please allow this letter, as well as the content in the attached application, to serve as our commitment to the Illinois Healthcare Transformation Grant and the Building Healthy Places Through Neighborhood Transformation collaborative (BHPTNT).

The Rockford Housing Development Corporation (RHDC) pledges to adhere to collaborative policies and agrees to honest dealing, acting prudently, ethnically, and in good faith regarding the BHPTNT Collaborative of which we are a part.

Rockford Housing Development Corporation will build a mixed-use building along with a yet to be determined number of multifamily and single-family homes on vacant land on Rockford's west side. The site includes acreage for an urban farm to be operated by others, under a reasonably termed ground lease agreement. The plot of land, and vacant infill lots, are within walking distance of the Crusader Health Clinic, its walk-in services, and an onsite full-service Walgreens pharmacy. Please see more about this commitment within the body of the grant application.

As you will see in the submission, the Board of the RHDC, has the experience, capacity, and capital to execute on this commitment.

The Rockford Housing Development Corporation commits 4 of its Board members to the project, with each bringing a special expertise. Members of the Rockford Housing Development Corporation who will be assigned to the collaborative are:

- 1) Jerry Lumpkins, President, (Chicago Commercial Real Estate Lead, Bank Leumi), Commercial Lending
- 2) Ron Clewer, VP, (Illinois Market President, Gorman & Company), Affordable Housing/Community Development
- 3) Phyllis Ginestra, Secretary/Treasurer (CFO, CDW Software) Finance, Budgeting, and Operations
- 4) Chandler Anderson, Board Member (Partner, USGreenlink), Energy and construction solutions

Further, as RHDC expands its team to execute on this project, including its planners, architect, and its developer, it will require commitments from each third-party team member to participate in the collaborative as part of their project obligations.



3400 N. Rockton Ave.
Rockford, IL . 61103

At present, the weekly hour commitment of the Rockford Housing Development Corporation Board currently stands at an average of 20 hours per week and will expand as the team grows to complete the projects herein.

In addition to our timing commitment, the RHDC is purchasing the South Avon Street property, the phase one site of our project. This is evidenced in the narrative and supporting materials in the application. The value of that property, with closing costs is \$200,000. Additional investments will be made over the life of the project; however, it is the timing of the other commitments that will drive the timing of those investments – these project-by-project subsidies may include Low Income Housing Tax Credits, HOME funds, CDBG funds, etc., commonly used in community development projects. RHDC liquidity currently stands at near \$5M. It is our intent to leverage those funds to bring other funds into the collaborative.

We believe these focused social determinants of health, integrated approaches, to neighborhood stabilization and restoration is a necessary and proven approach to improve resident health outcomes, address social and economic justice, and increase individual and family well-being. We are hopeful you see this too.

Thank you for this innovative opportunity that aligns and supports our collaborative - Building Healthy Places Through Neighborhood Transformation.

Respectfully submitted,

A handwritten signature in black ink that reads 'Jerry Lumpkins' in a cursive script.

Jerry Lumpkins
President, RHDC



November 19, 2021

To whom it concerns:

Region 1 Planning Council (R1) pledges to adhere to collaborative policies and agrees to honest dealing, acting prudently, ethnically, and in good faith regarding the collaborative of which it is a part. The collaborative is the Building Healthy Places Through Neighborhood Transformation collaborative (BHPTNT) for the Illinois Healthcare Transformation Grant.

R1 will be the financial intermediary for the collaborative, managing and allocating the funds to the members, in coordination with Swedish American/UW as fiscal agent. R1 will also be in charge of creating and maintaining a data dashboard and data sharing relationships with all of the collaborative partners. This data dashboard will be public facing and be used by the collaborative partners to inform their decisions, priorities, and report on the progress of their objectives.

R1 will also be in charge of convening and administering the Core Team--a set of representatives from each partner and working group which tracks progress and sets goals for the collaborative and handles communication with other entities.

Signed,

A handwritten signature in black ink that reads "Michael P Dunn Jr." with a stylized flourish at the end.

Michael Dunn Jr., Executive Director
815-319-4180 | mdunn@r1planning.org



To whom it concerns:

Swedish American, a Division of UW Health, pledges to adhere to collaborative policies and agrees to honest dealing, acting prudently, ethnically, and in good faith regarding the collaborative of which it is a part. The collaborative is the Building Healthy Places Through Neighborhood Transformation collaborative (BHPTNT) for the Illinois Healthcare Transformation Grant.

Swedish American, a Division of UW Health, will be the financial agent for the BHPTNT collaborative. The Regional 1 Planning Council as the financial intermediary.

Swedish American, a Division of UW Health, will staff and operate a mobile health unit which will deliver preventive and primary care to communities in Rockford currently facing healthcare outcome disparities with the goal of improving measurable healthcare outcomes and decreasing the financial burden the residents of these communities place on the healthcare system at large.

Hours and Staffing: Swedish American, a Division of UW Health, will commit Four staff members to the project to implement and operate it. The staff to operate the mobile health unit are: Mobile Health Unit RN Coordinator, Advanced Practice Registered Nurse, Medical Director, Administrative Assistant. Employees of Swedish American who will be assigned to the collaborative are: Mobile Health Unit RN Coordinator, E. Sue Thompson, RN., Medical Director, Dr. Mohammed Shareef., Administrative Assistant, Kathy Toldo. Advanced Practice Registered Nurse to be determined. Additional staff will be added as the needs of the project increase over the course of five years.

The weekly hour commitment of the van staff is Mobile Health Unit RN Coordinator 0.6 fte, Advanced Practice Registered Nurse 0.5 fte, Medical Director 0.1 fte, for a total of 48 hours. In addition, the Administrative Assistant 0.2 fte will add 8 hours per week for a total of 56 hours for the first year of the project. Each subsequent year will bring additional staff and hours. For projected growth in staffing, please see MHU budget proposal.

Program Overview: The Mobile Health Unit (MHU) program will consist of a dual approach that will include stationary events in targeted communities as well as mobile prevention programs that reach rural impact areas. The mobile van will be staffed by medical practitioners with prescribing capabilities and behavioral health specialists affiliated with partnering organizations (i.e. medical students from the College of Medicine, etc). Organizations will work to create seamless intervention strategies that will reach urban and rural communities. Areas of future interest include behavioral health research, family practice interventions and research, and applied behavioral analysis (ABA).

Swedish American, a Division of UW Health, will coordinate with Mile Square so Mile Square will provide tele-health service in the mobile health van. Swedish American, a Division of UW Health, will also coordinate with the Region 1 Planning Council to provide de-identified data on the communities it is serving so the Region 1 Planning Council can create and update a data dashboard to inform the collaborative partners on the evolving needs and performance of the communities it is serving.

Focus: SAHS and Molina HealthCare have determined collaboration for the provision of mobile health care and supportive services throughout the greater Rockford service area, for the purpose of providing health care access to vulnerable populations.

Covered Services: The providers would seek reimbursement as covered services where appropriate. The provider anticipates making all necessary referrals for longer term resources as is customary with other existing community partnerships.

Targeted Population: The mobile van will be open to both members and nonmembers within the target area (i.e. Winnebago County and surrounding areas).

Stakeholder Contributions:

1. Molina will sponsor the cost of one mobile health unit (van).
2. SAHS and Molina will work collaboratively regarding usage of the MHU at Molina-sponsored community health and other special events.
3. SAHS will collaborate regarding the scheduling and provide staffing for the events. SAHS will maintain all required maintenance, insurances, etc. for the mobile vehicle.
4. The City of Rockford and SAHS may utilize the MHU for the furtherance of community health and prevention outcomes.

The City of Rockford will also facilitate connections to supportive services and poverty mitigation resources through direct referrals to the Human Services Department and other social service agencies.

Signed,



E. Sue Thompson, MSN, RN, CNML
Director of Emergency Services
UW Health SwedishAmerican Hospital



Connecting the Dots for Better Health



November 17, 2021

To whom it concerns:

The Rockford Regional Health Council pledges to adhere to collaborative policies and agrees to honest dealing, acting prudently, ethically, and in good faith regarding the collaborative of which it is a part. The collaborative is the Building Healthy Places Through Neighborhood Transformation collaborative (BHPTNT) for the Illinois Healthcare Transformation Grant.

Rockford Regional Health Council improves community health through data gathering and analysis, education, and advocacy. Our vision is to be a catalyst for collaboration to assure a healthy community with access and quality care for all. The Council will work in close communication and coordination with the BHPTNT collaborative to help integrate their efforts and their served clients with the greater healthcare system of the Rockford Region.

There is a lot of strain on the current healthcare system in Rockford and the BHPTNT is making efforts to help relieve some of that strain in the short and long term, with the ultimate goal of improving the disparity between racial and ethnic groups and making the existing healthcare system more effective. This proposed project is an excellent fit with the Council's current priorities of addressing Disinvested and Vulnerable Neighborhoods and Specific Morbidities. The Health Council looks forward to collaborating with all of the partners on this grant, and furthermore, coordinating future community health planning with the collaborative partners and in alignment with the data dashboard.

Signed,

A handwritten signature in black ink that reads "Rebecca Kendall".

Rebecca Kendall
Executive Director



Mailing Address
1200 West State Street
Rockford, Illinois 61102-2112
p 815.490.1600
f 815.490.1625
www.crusaderhealth.org

Locations: **Rockford** Crusader Community Health on West State Street – Woodward Campus for Community Healthcare
Rockford Crusader Community Health on Broadway – Uram Building
Belvidere Crusader Community Health Belvidere
Loves Park Crusader Community Health Loves Park

November 17, 2021

To whom it concerns:

Crusader Community Health is very supportive of the work being done by the Building Health Places Through Neighborhood Transformation (BHPTNT) collaborative. We feel their efforts will interlock and interplay very well with our efforts and goals and provide an overall transformation to healthcare in our communities that is more than the sum of its parts.

Of particular note to us is the work being proposed by the Rockford Housing Development Corporation to turn a vacant lot into a series of homes, a mixed use building with childcare, and an organic community garden. The lot they have chosen for this project is within walking distance of our new facility on the underserved west side of Rockford.

Our facility offers walk-in services, primary care services, behavioral health services, dental services, optical services, and houses a full-service Walgreens. Adding this new boom of affordable housing to the area will, in our minds, turn the area into an incredibly resilient and health-adapted community.

For these reasons, Crusader Community Health is very happy to pledge their support to the BHPTNT collaborative.

Sincerely,

Sam Miller

President and CEO

Crusader Community Health

Care Within Reach

ILLINOIS HOUSE OF REPRESENTATIVES

401 SOUTH SPRING STREET
242A-W
SPRINGFIELD, IL 62706



4007 NORTH MULFORD ROAD
LOVES PARK, IL 61111

DAVE VELLA
STATE REPRESENTATIVE
ILLINOIS 68TH DISTRICT

November 18, 2021

To whom it concerns:

The communities of Hispanic and people of color in Rockford have long suffered from inequality. One of the clearest ways this is visible is in access to healthcare of all forms. There exist many disparities in both access to care and healthcare outcomes between our people and communities along racial and ethnic lines.

Much of these disparities are geographic in nature as well. Rockford's west side is home to far fewer overall necessary facilities for a healthy life and is also home to most of our racial and ethnic minority individuals and communities.

The Illinois Healthcare Transformation grant is seeking to address the root causes of these disparities in healthcare: the social determinants of health. The Building Healthy Places Through Neighborhood Transformation Collaborative is made up of organizations with a long history in the city and with direct access and input to the suffering communities.

Direct community input has informed every step of their plan and their focus is on getting as many dollars of awarded money directly to the people in need. They will foster community food systems, giving people access to healthy food. They will construct affordable housing, giving people a wealth-building asset and a stable home. They will create a mobile health unit, to bring primary and preventative care directly to any neighborhood or street corner that needs it.

For these reasons, I strongly support the efforts of the Building Healthy Places Through Neighborhood Transformation Collaborative in all they plan to do. It is our hope that their efforts will begin mending at least some of the harm done by years of legislated and systemic racism and discrimination which have plagued the people of color and Hispanic populations in the Rockford region.

Sincerely,

A handwritten signature in black ink, appearing to read "Dave Vella", with a long horizontal flourish extending to the right.

Dave Vella
State Representative
Illinois - 68th District

ILLINOIS HOUSE OF REPRESENTATIVES

DISTRICT OFFICE:
EJ "ZEKE" GIORGI CENTER
200 S. WYMAN STREET
ROCKFORD, IL 61101
(815) 987-7433



SPRINGFIELD OFFICE:
290-S STRATTON BUILDING
SPRINGFIELD, IL 62706
(217) 782-3167

MAURICE A. WEST II
STATE REPRESENTATIVE | 67TH DISTRICT

November 16, 2021

To whom it concerns:

I am writing to you today to express my support for the Building Healthy Places Through Neighborhood Transformation Collaborative and their application for the Illinois Healthcare Transformation grant. The efforts proposed by this collaborative will go a long way to breaking down barriers, improving access to care, and transforming healthcare outcomes in our most underserved neighborhoods.

Rockford's minority and socioeconomically disadvantaged communities have long suffered from inequality. One of the clearest ways this is visible is in access to healthcare. Rockford's west and south sides are home to much of our minority community and far fewer overall resources for a healthy life including a lack of medical care, food deserts, and weak access to quality housing. This has resulted in poor healthcare outcomes and inequities that have only become more exacerbated during the pandemic.

The Illinois Healthcare Transformation grant is seeking to address the root causes of these disparities in healthcare, the social determinants of health, to find sustainable solution to improve healthcare outcomes and account for unique community needs. For any collaboration to be successful in achieving this goal, they must have a strong relationship with the community they serve. That is why I am excited that the Building Healthy Places Through Neighborhood Transformation Collaborative is comprised of organizations with a long history in the city and with direct access and input to the suffering communities.

Community input has informed every step of this plan and the organizations involved are focused on maximizing the services that can be provided to the community. They will foster community food systems, giving people access to healthy food. They will construct affordable housing, giving people a wealth-building asset and access to a stable home. They will create a mobile health unit, to bring primary and preventative care directly to any neighborhood or street corner that needs it.

For these reasons, I strongly support the efforts of the Building Healthy Places Through Neighborhood Transformation Collaborative in all they plan to do. It is my hope that their efforts will have a significant impact on the health outcomes for our underserved neighborhoods. I ask that you give their application full consideration so that they may transform healthcare in Rockford.

With kind regards to you and the constituents we serve, I remain,

Yours sincerely,

A handwritten signature in blue ink, appearing to read "Maurice A. West II".

Maurice A. West II
State Representative | 67th District

200 S. WYMAN, SUITE 301
ROCKFORD, IL 61101
PHONE: 815-987-7557
FAX: 815-987-7529



121B STATE CAPITOL
SPRINGFIELD, IL 62706
PHONE: 217-782-8022
WEBSITE: www.SenatorStadelman.com

ILLINOIS STATE SENATE
STEVE STADELMAN
STATE SENATOR • 34TH DISTRICT

November 17, 2021

To Whom It May Concern:

I'm acutely aware of the inequities people of color face in my community, having represented Rockford in the Illinois Senate since 2013 and having reported its news as a broadcast journalist for 25 years. In health care, the disparity is abundantly clear.

Access to care and patient outcomes differ along racial, ethnic and geographic lines. Fewer medical and wellness facilities operate on Rockford's west side, where many Black and Brown families live.

Building Healthy Places Through Neighborhood Transformation is a collaborative of organizations with long histories, strong reputations, frontline experience and deep understanding of Rockford's disadvantaged populations. I believe the collaborative is well equipped to make wise use of an Illinois Healthcare Transformation grant.

I'm impressed with the level of direct community input that shaped the collaborative's plan and pleased with the focus on devoting as much grant funding as possible to direct assistance through community food systems to offer access to healthy food, affordable housing to provide stable places to live and wealth-building assets for families and a mobile health unit to bring primary and preventative care right to the street corners of people in need.

In my opinion, Building Healthy Places Through Neighborhood Transformation could begin to mend the harm done by systemic racial and ethnic discrimination that has plagued Rockford. I wholeheartedly support the collaborative's application for Illinois Healthcare Transformation funding to help accomplish this important work.

Sincerely,

A handwritten signature in cursive script that reads "Steve Stadelman".

Steve Stadelman
State Senator, 34th District of Illinois



Thomas P. McNamara
Mayor
Office of the Mayor

November 17, 2021

To Whom It Concerns:

The communities of Hispanic and people of color in Rockford have long suffered from inequality. One of the clearest ways this is visible is in access to healthcare of all forms. There exist many disparities in both access to care and healthcare outcomes between our people and communities along racial and ethnic lines.

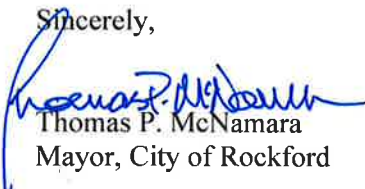
Much of these disparities are geographic in nature as well. Rockford's west side is home to far fewer overall necessary facilities for a healthy life and is also home to most of our racial and ethnic minority individuals and communities.

The Illinois Healthcare Transformation grant is seeking to address the root causes of these disparities in healthcare: the social determinants of health. The Building Healthy Places Through Neighborhood Transformation Collaborative is made up of organizations with a long history in the city and with direct access and input to the suffering communities.

Direct community input has informed every step of their plan and their focus is on getting as many dollars of awarded money directly to the people in need. They will foster community food systems, giving people access to healthy food. They will construct affordable housing, giving people a wealth-building asset and a stable home. They will create a mobile health unit, to bring primary and preventative care directly to any neighborhood or street corner that needs it.

For these reasons, I strongly support the efforts of the Building Healthy Places Through Neighborhood Transformation Collaborative in all they plan to do. It is our hope that their efforts will begin mending at least some of the harm done by years of legislated and systemic racism and discrimination which have plagued the people of color and Hispanic populations in the Rockford region.

Sincerely,


Thomas P. McNamara
Mayor, City of Rockford